Book 04

PUBLIC HEALTH RESOURCE NETWORK

PHRN

Community Participation and Community Health Workers: with Special Reference to ASHA

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
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Book 4

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Community Participation and Community Health Workers:

With Special Reference to ASHA

PHRN

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Preface

Public Health Resource Network

The National Rural Health Mission's vision of a national programme planned at the district level, and if possible at the village level, needs an exponential increase in capacities across the board. The NRHM has initiated many steps in this direction. However the nation is vast and diverse. And there are many constraints in existing planning and implementing structures that would need to be overcome. This calls for the official national mission-led process to be supplemented with many varied, creative and massive endeavors at capacity building. State governments, health resource centers, different professional sections and different sections of civil society all need to contribute to meeting these enormous needs of capacity building.

This initiative, called the Public Health Resource Network (PHRN) aims to provide support to public health practitioners working in the districts in all aspects of district health planning and public health management. The central element of this initiative is a capacity building effort structured as a distance learning programme. This distance learning programme is not a substitute to formal professional public health training and it does not carry with it any guarantee of increased employment or career options. It is meant to support individuals and organisations both within and outside the health department who are committed to working for a more equitable and effective public health system. This programme complements official training and education programmes through an open-ended, more informal and immediate reaching out with information, tools and a diversity of programme options and perspectives.

The course faculty and editors of the modules are drawn up exclusively from those who have been active in various states in providing support to governments and non governmental organisations in health and related sectors. This

programme itself is being organised primarily by a number of agencies already providing resource support to states on different aspects of NRHM programmes.

A Mission needs Missionaries, and it needs them where the challenges are greatest- in the remote and most underdeveloped areas of the northern and eastern states, and indeed in all the under-served areas of all the states. A Health Mission needs these missionaries to also be professionals, where being a professional is not one more form of privilege- but a competence that anyone willing to put in the time and effort – and a little expense – can acquire! Thus the contact programmes at district, regional and state level would evolve into mechanisms of sharing of resources, and building mutual solidarity amongst those who work for change, and of those who work in the health sector because they seek to work for the poor. The true test of the programme is thus not the number of certificates that we issue but the better quality of district plans, a higher motivation of district teams and eventually better health outcomes in the district. The immediate context is the National Rural Health Mission. But hopefully the voluntary network that emerges will contribute over the years to the evolution of a network of district and block level resource groups who provide technical support to all efforts at decentralised planning in governance and to all societal efforts towards an equitable and just society.

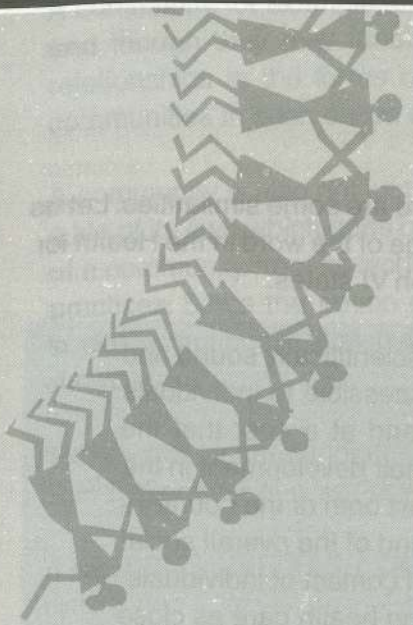
In this book, the fourth volume of the PHRN series, we discuss the community health worker programme as a strategy of community participation, in the context of the ASHA scheme. Drawing considerably upon the Mitanin programme experience, we examine the problems that occur when the community health worker programme is scaled up from the usual 50 to 100 village size where many NGOs have shown 'success stories,' to the size of a state. This book is a critical input into understanding and executing the ASHA programme.

We plan to update and revise this book, like all other books of this series, based on the feedback we receive from the districts. The PHRN looks forward to your learning from these books as well as your participation in the creation of future editions of these books. This book may have centered itself on the Mitanin experience, because there is, as yet, no other similar state experience. But as the ASHA programme rolls out subsequent editions would capture the best practices that would invariably emerge from many other states as well.

Dr. T. Sundararaman
PHRN Programme Coordinator

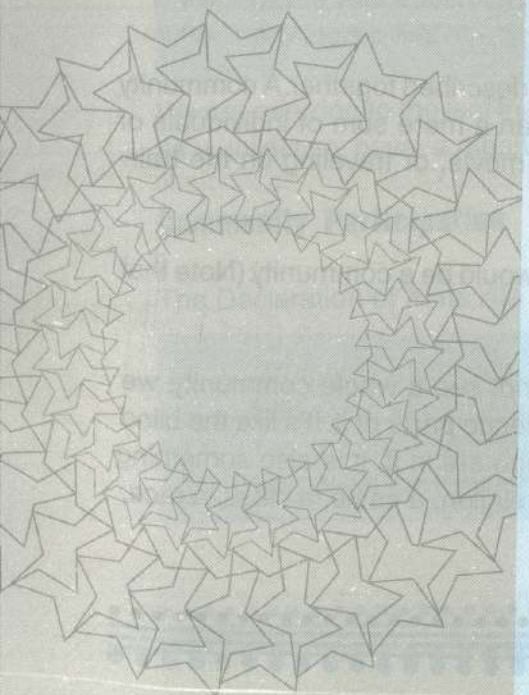
Lesson ONE

Understanding Community Participation



In this lesson we shall discuss:

- The terms 'community' and 'community participation'
- Why community participation is essential and important
- Forms of community participation
- Problems and limitations of community participation.



COMMUNITY

The meaning of the word community changes with the context of its usage. Look at these three sentences:

The *community* should select the ASHA.
He is a specialist in *community* medicine.
I belong to the kurmi *community.*

In each case the word community means something different, and yet there are some similarities. Let us therefore define in what context we are using the word community.The usage of the word in the Health for All declaration explains this very well. The Alma Ata declaration Paragraph VI states:

> "**Primary health care** is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the **community** through their full participation and at a cost that the **community** and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the **community.** It is the first level of contact of individuals, the family and **community** with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process." [emphasis added]

DISCUSSION

What does community mean in the above paragraph?

The community is used as a collective noun. It implies a number of people described together. A community is made up of individuals and it is made up of families but it is more than a mere sum of individuals or families. A number of individuals or families coming together to see a movie, or traveling on the train would not be a community.

But a group of families attending a wedding or living together in a village would be a community. (Note that there are some persons in a community who are not part of a family).

The concept of a community does not fit into a neat package. We cannot see a whole community, we cannot touch it and we cannot directly experience it. We can only experience parts of it. It's like the blind men touching the elephant story. A community is not just the people who are in it, it is also something beyond it. A community may be defined on the basis of a geography, a religion, a caste, a class, a race,

or some other common interest.There may also be similar behaviours and expectations, based on shared values, beliefs, and meanings between individuals.

A community, for example, of partially isolated small hamlets, may have fuzzy geographical boundaries, and though they may function on a daily basis as an integrated community, they may be seeking relationships in the forms of marriage and trade with residents of other villages. The boundaries of communities in such cases do not remain precise.

A community is also not just a collection of individuals, but a socio–cultural system.The community has a life of its own which goes beyond the sum of all the lives of all its members. All socio-cultural elements of a community from its technology to its shared beliefs are transmitted and stored through symbols and practices. Since the notion of 'community' is a social construct, it is critical to understand that like all social institutions, it is also a changing set of relationships, including the attitudes and behaviours of the members.

Hence this understanding of communities and their internal and external dynamics should be kept in mind whenever one works with communities.

THE COMMUNITYAND THE NATION

A nation is made up of communities- but a community is distinct from the nation. But then, we can also speak of the concept of a community of nations. The Declaration of Alma Ata states:

> "A main social target of governments, international organisations and the whole **world community** in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life."

We are referring to the fact that nations do not stand alone.They are bound together, interdependent, and as a collective, have a meaning which is more than all of them taken separately or merged together.

Community Participation

The Declaration of Alma Ata states: Para VII:

> "Primary health care..... requires and promotes maximum **community** and individual self-reliance and **participation** in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of **communities to participate**;"

The statement represents the following key ideas related to community participation:

Primary Health Care Requires community participation
Primary Health Care Promotes community participation.
Primary Health Care Develops the ability of communities to participate

But why this emphasis on Community participation? There are four well known reasons for this emphasis. They are:

a. A major part of the morbidity and mortality that people face are due to causes that can be either prevented through simple measures and treated through simple remedies or that can be managed by communities themselves. This is particularly true of less developed nations and communities where the pattern of illness is such that it admits of such management.
b. Health services are often underutilised. This is often because there is a mismatch between people's needs and what the services deliver. If communities are involved in planning and delivery of services much of these problems underlying poor utilisation could be addressed.
c. People have both a right and a duty to be involved in the decisions that affect their lives. This increases their self –reliance. The experience of participation in one domain makes them more confident and empowers them to act on many other areas that affect their lives.
d. Communities possess resources of human power, natural resources like medicinal herbs, indigenous knowledge, and even financial resources that can be used to enhance the quality of health care and effectiveness of health care services.

Are not the above facts obvious? And yet there is a lot of resistance to translate the idea of community participation into practice.

To explain, we give below a few typical quotations of some decision makers :

A senior health administrator : "It is not possible to change these people. If we must get them to change their practices , one has to be coercive(forceful). Tell them that if they do not get immunised they would not get rations. Or tell them that if they have more than two children then they would be disqualified from the Panchayat."

Consultant : "To promote this contraceptive we need to flood the market with advertisements, surrounding people with messages about it and invest in building a brand image for it and also give them a financial incentive for using it.

An official: For promoting the completion of their course of drugs, one needs to give tuberculosis patients a financial incentive. Otherwise there would be no change. This is true for institutional deliveries also.

Doctor to Patient who asks him whether he can do without the drugs: "Am I the doctor or are you the doctor? Just take this medicine as I am telling you."

What is common to these four quotes given above?

All approached the issues with a lack of confidence in people's desire to be healthy and their ability to make rational decisions about how they choose to do so. Like a father forcing a small child to take medicines, the system has a paternalistic view point that it must somehow coerce, trick, bribe or command the individual or the community seeking healthcare to simply accept what the government is offering in the way of healthcare services.

Often the health system sets itself up in a way that it appears to convey that those who need to be healthy and who need treatment for illness do not themselves care, but the government must somehow persuade them to be healthy and to get themselves treated.The term "beneficiary" itself and the prevailing attitude imply a passive beneficiary who only consumes health care services that drop down from above.

> **"But individuals, families and communities DO want to remain healthy. And most often, they make rational decisions and choices about health care."**

If they do not utilise the health services available, or choose certain unhealthy practices, we need to first explore the reasons for these choices and then move to address them contextually. We should not assume that this is irrational behaviour and requires coercion, incentives or marketing strategies to provide the solutions. At any rate if people for whatever reason, are not convinced, health cannot be forcibly fed to them.

Case Study

Kusum has tuberculosis. She is unable to continue her drugs regularly. She takes for three months and then discontinues. There are two ways of looking at this problem and there are two ways of addressing this problem.

Approach 1: *People do not understand however much you tell them. Once their cough stops they discontinue their drugs. Or become quite careless, taking the drugs home and not eating it- just throwing it away. Kusum is just a typical example of this. But because of these defaulters the disease keeps spreading also. Therefore we need to ensure that someone takes the drugs to them and gives each dose to them and sees to it that they eat it. We can provide her with some funds for travel to the CHC. We should also make the patient sign a bond or pay a deposit promising to complete the course.. Or at least impose a fine by the Panchayat if they default.*

Discussion

Each of the above five examples represent a level of participation

1. What are the aspects that determine the level of participation that actually takes place?
2. Is it willingness of the Department to allow such participation?
3. Is it the willingness of the community to be so interested?
4. Is it the capability of the community to participate at that level?
5. Is it the presence or absence of institutional mechanisms or programme designs that facilitate or limit community participation?

However as the Declaration of Alma Ata is clearly committing the world community to an understanding of community participation where:

> "Primary health care..... requires and promotes maximum community and individual self-reliance and participation in the **planning, organisation, operation and control of primary health care,** making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of *communities to participate*"

The question is therefore not of whether to go up to the 4th and 5th level of community participation or not, but how to go there?

False Expectations of Community and Community Participation

Often those who have tried to mobilise communities get frustrated easily. They find people uncooperative, or disagreeing with one another, frequently encounter ego problems etc. So a programme officer would often say, "This is all alright in theory. But it does not work in practice".

In the health sector today, most often when we talk of a community we refer to the village or habitation. One of the problems faced in implementing concepts like community participation with reference to the village is that the village is viewed as a singular homogeneous entity- with all people within it having equal rights, equal interest, equal power- and all the differences and power dynamics and relationships within the village are either forgotten or not addressed.

We need therefore to remind ourselves:

A village is NOT homogeneous. There are differences of gender, caste, economic status and control over assets, access to powerful people outside the village, relationship with traders etc. – all make for very many different views and needs. Some groups have privileges that the others do not have and are dominant. They have their way in decisions, and can control major decision making to be favourable to

themselves. Sometimes their decision prevails even if it goes against the majority interests. Very often, especially if we are not careful, what we hear as the voice of the "community" is the voice of the upper caste, landed gentry, who by virtue of their caste and economic class, dominate the village.

> **"A village is NOT homogeneous. There are differences of gender, caste, economic status and control over assets, access to powerful people outside the village, relationship with traders etc. – all make for very many different views and needs."**

Even if we encourage, facilitate and hear the voices of weaker unrepresented sections, the dominant sections may never come around to agreeing with the decisions that get taken. For instance, the selection of the ASHA may indeed get made keeping in mind that she needs to be a representative of the more vulnerable groups that may need her services the most. But though unable to prevent such a decision in the village, the dominant groups may never quite with their hearts and attitude agree to it. It is just not acceptable in many villages, for example, for a dalit woman to teach essentials of health care to an upper caste family. Yet if a dalit woman is not chosen, the messages would hardly reach the dalit community within the village.

That is why many planners avoid the word community altogether and talk of the weaker or marginalised sections of society. We therefore need to remind ourselves that when we talk of community participation in the health context, we mean all those in the village, but with special facilitation and affirmative action to see that the weaker and hitherto unheard voices are indeed heard and their needs are addressed- for their health needs are more and their need for support is also greater.

Case Study

Baburam, the Block Extension Educator of Sariya block, has to organise a Family Health Counseling Camp as part of the HIV, STD, family planning counseling programme. He goes straight to the house of Ghanshyam, whom he has identified as the community leader. Though he is not Sarpanch, he always nominates the candidate for the post of Sarpanch. Ghansyam owns the majority of the land in his village and most of the people work on his fields or have taken loans from him (or will need to take loans from him). His borewells supply water to many fields. He is always ready to meet Baburam and is very helpful. The ambulance can be parked inside his compound and the doctors can use his rest rooms. He arranges for one or two servants of his to help set up the camp, and sends another two of his supervisors around to tell all the villagers to turn up for the meeting. The villagers turn up, but with little interest and even less enthusiasm. They listen passively and go away. Baburam is happy – the camp went off well. But why is Ghanshyam happy? After all he spent his money and time.

There is no increase in RTI referrals or people coming for voluntary testing, or for counseling. Obviously the camp did not work. Does this show that community participation does not work, or is there some

other problem? Ghanshyam and Baburam know the answers. "The people are illiterate. They are unwilling to change. They are just like that." Could you question these answers that such people have?

In addition, there are some other common expectations or notions of community participation that are often misplaced or not true:

1. Informing the community will automatically lead to behaviour changes.
2. Community leaders act in the best interests of the people and the people always believe in them.
3. Government, community leaders and community all share the same goals and would agree on the same means for community development.
4. Increased community participation would mean fewer conflict situations with local health authorities and with planners.

Keeping the same case study given the above and building on the case study can these be discussed.

Mechanisms of Community Participation at the Village Level

1. Informal Meetings/Events: This is the most common form of initiating interaction with communities. The health department person calling in members of the community to cooperate or attend the meeting when the need arises. Invariably the health department initiator would need the assistance of one or two members of the community whom he finds himself close to.
2. Community Health Volunteer: Letting the community select one or more persons and training them so that they are able to provide support to the programme, then having them as the main channel of communication between the village and the health department.
3. Village/Hamlet Health Committee: Encouraging the community to form a representative committee, or a women's representative committee, to discuss health programme and coordinate with the health department. This could be combined usefully with the selected volunteer acting as a support and facilitator of this committee.
4. Community Based Organisation: Building a relationship with a pre-existing community based organisation- like a womens self help group, or a youth club, a womens association, or a milk producers cooperative, or a landlessworkers union etc. By definition most of them are resident in the same village and participating voluntarily. If these provide more representation for weaker sections, then there are advantages to be gained by using these as the village committee. But if they also represent only the more well to do sections within the village, then it could be a disadvantage. However community based organisations have a greater certainity of regular functioning, and a solidity that the womens health committee does not have and this needs to be considered.
5. Statutory Committee of the Panchayat: The elected Panchayat is to set up a health committee that is representative and that can be delegated powers and be allowed to make or approve heath plans. The advantage is that it can, by law, be given formal authority and powers. In practice it can ensure that community health volunteers and all those interested can participate in discussions even if they are not formal members, though they cannot participate in the voting.

6. Non Governmental Voluntary Organisations: These may represent those interested in changes in certain areas, out of their own commitment. They can play a useful role in voicing community concerns. However often they are only implementing projects of the government and their consciousness is not of representing peoples interests but as a contractor of government services.
7. Public Participation in Statutory Management and Advisory Committees: Most committees made of government functionaries of different departments to oversee the development of health facilities or District Health Societies admit some participation for the community as different from the representatives of the government and of the Panchayat. How to decide who voices the community opinion in this context is difficult to decide. Therefore the rule is to always have the elected representative because by definition he or she represents the community. Then over and above their presence, allow for some other community representatives specifying what section or concern is being thus articulated. Thus one may bring in women to articulate women's issues, or bring in representatives of CBOs or NGOs because they are playing an important role in programme implementation. If we are clear what strengths are needed in a committee the guidelines can be written up such that a fair choice is made. Political intervention in such representation is often seen as a problem and sometimes it is a problem. What needs to be realised is, that for democratic functioning, some political involvement in these committees is needed as well.

Discussion

Study the examples of community participation in your area. Ask the health department officer to list some examples of community participation which are functional and working. Which of the above mechanisms are in place? Are they all of type 1 or are there examples of other mechanisms as well. And in these examples also note if community participation empowers the weaker sections within communities-

CONCLUSION

Given the fact that there is a power structure functional within communities and that the voices of the elite and privileged within communities may substitute for the voice of the entire community, how do we secure a more active participation from weaker sections. It is not only economic or caste dominance that weighs on the weaker section - it is a whole long tradition of being influenced by values and norms of dominant sections passively. Thus for example many women have internalised the values that women should remain silent, not speak up against domestic violence and their health needs are not as important as anyone else in their family.

Getting the whole community to act, to take ownership on the mechanisms of community participation, to participate in decision making requires a process often referred to as community mobilisation. We shall discuss this later in lesson 6.

Primary Health Care without community participation is neither desirable nor feasible. But getting those within the community whose needs are greatest to participate equally and meaningfully is a challenge.

Review Questions

1. What is a community? Explain with a diverse set of examples.
2. Why has there been a reluctance to promote community participation in health care services?
3. What are the levels of community participation?
4. Give five examples of forms or mechanisms of community participation in health programmes.
5. What are the diverging perspectives and groups within a village?

Application Questions

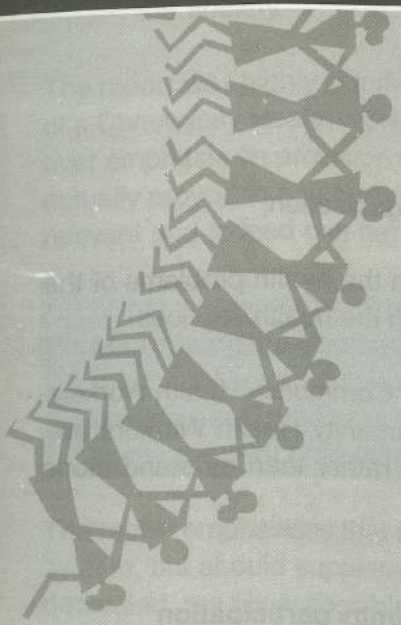
1. What is the 'glue' that holds a community together?
2. How do individuals function independently within interdependent social settings? How do individuals negotiate social and community spaces, to hold a different practice or belief?
3. What are the inter connections between cultural and power dimensions of communities? (i.e. practices of the upper castes/ classes may get blindly accepted and imitated as the norm by all other castes and classes, eg for example certain beheviours associated with patriarchy like dowry and pardah evolved as an upper caste practice, now seeping into all castes).

Project Work

1. List the health programmes in the district today which provide for some form or other of community participation. Decide what level of community participation they belong to.
2. Meet a few village health committees. What decisions did they make? Which of these were implemented?

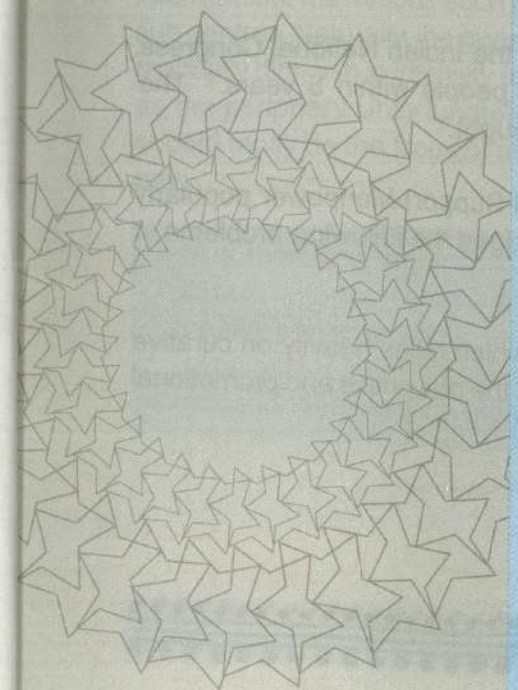
Lesson TWO

Community Health Workers



In this lesson we shall discuss:

- What are the objectives for, and expectations from Community Health Workers/Volunteers.
- How do these make them different from other categories of health care providers/workers.
- A brief history of the concept.
- Essential features of successful community health worker programmes.
- Scaling up community health worker programmes: The Mitanin programme.
- The main features of the ASHA programme.



DEFINITIONS

The WHO study group of 1989, updating an earlier conceptualisation of CHWs in the Alma Ata Declaration (1978), defined the Community Health Worker as:

- Members of the communities where they work,
- Selected by these same communities,
- Answerable to the communities for their activities,
- Supported by the Health System but not necessarily a part of its organisation,
- Having shorter training than professional workers.
- Men and women chosen by the community and trained to deal with the health problems of the individuals and the community, and to work in close relationship with the health services.

It was understood in almost all models of community health volunteers that Community Health Workers are generally part-time volunteers rather than professional workers. Community Health Workers are seen as a mechanism of community participation and community action rather than as stand alone service providers at the hamlet/village level.

> **Community Health Workers are seen as a mechanism of community participation and community action rather than as stand alone service providers at the hamlet/ village level.**

A Brief History of the Concept: Three important milestones

1. In India, as early as in 1940, Nehru chaired a Planning Committee of the Indian National Congress, which recommended the training of one health worker for every 1000 people within 5 years.[2] The programme for village doctors had earlier also been part of Gandhian thought.[3]

2. In 1975, the landmark 'Report of the Group on Medical Education and Support Manpower' popularly known as the **Shrivastava Committee Report**, identified and acknowledged the following problems in medical education and health service:[4]

- The essentially urban orientation of medical education in India, which relies heavily on curative methods and sophisticated diagnostics aids, with little emphasis on the preventive and promotional aspects of community health,

- The failure of the programmes of training of medical practitioners in the fields of nutrition, family welfare, and maternal and child health, and
- The deprivation of the rural communities of doctors, in spite of the increase of their total stock in the society.

The report was highly significant because for the first time there is a clear explanation for the critical need of a Community Health Worker (CHW) in the Indian context. The report explains that this is to correct the over emphasis on provision of health services through a professional staff under state control which has actually proved to be counter productive. Its lucid description of the profile of CHWs remains extremely relevant and indeed can hardly be improved even today.

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

The report emphasises that the CHW should not supplant or competete in any way with the formal health system, but should supplement it. It lays great emphasis on creating a professional, highly competent, dedicated, readily accessible, and almost ubiquitous referral service to deal with minority of complicated cases that need specialised treatment.

It perceives this proposed shift of focus to communities as carrying the potential to democratise health services. In the existing system, the entire programme of health services has been built up with metropolitan and capital cities at its centre and the programme tries to spread itself out in the rural areas through intermediate institutions such as Regional, District or Rural Hospitals and Primary Health Centres and its sub centres. Naturally, the quantum and quality of the services in this model are at their best in the centre, gradually diminish in intensity as one moves away from it, and admittedly fail at what is commonly described as the periphery. Unfortunately, the 'periphery' comprises about 80 per cent of the people of India who should really be the focus of all the welfare and developmental effort of the State. The report goes on to say:

> "It is, therefore, urgent that this process is reversed and the programme of national health services is built with the community itself as the central focus. This implies the creation of the needed health services within the community by utilising all local resources available, and then to supplement them through a referral service which will gradually rise to the metropolitan or capital cities for dealing with, more and more complicated cases."

3. In 1978, the path-breaking International Conference on Primary Health care in Alma Ata advocated the CHW as a central agency to advance primary health care. The declaration states:

> "Primary Health Care.....relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community."

Such a declaration was possible because a number of international experiences - the barefoot doctors of China, the health workers programmes in Mexico and the Jamkhed experience - had shown that it is possible to get a considerable improvement in health indices by the basic skills that a member of the local community could be trained for in a short period of time.

The same conference that adopted this declaration called for the creation of national level CHW programmes to be able to reach unreached populations, especially village communities and their unmet health needs, preventive, promotional and curative.

INTERNATIONAL EXPERIENCE WITH COMMUNITY HEALTH WORKER PROGRAMMES

The CHW owes its origin to the Chinese barefoot doctor in the 1950s during the people's revolution in China, as explained in the introduction to the WHO book for health workers (WHO 1987). The failure of health care models prevalent in various countries (India included) to meet the health needs of communities spurred the primary health care approach to meet the goals of Health for All at Alma Ata. This included an important role for CHWs.

David Werner, who was involved for many years in helping to establish a primary health care network in a remote mountainous region of Mexico, summed up the differences between medical professionals and Village Health Workers (VHWs) as follows (as quoted by Sanders):

> "The VHW we describe and suggest as a means of increasing the impact of the people within the health sector is distinguished from the auxiliary [medical worker] in the following crucial respects. The VHW:
>
> 1. Should be selected by the people from among themselves and should be responsible primarily to them, not to the health professionals.
> 2. Should be part-time and able therefore to subsist by performing agricultural or other work, possibly receiving a subsidy from either the local community or the national health service.
> 3. May be someone who has already been a traditional healer or birth attendant and should preferably be trained in the community in not only curative but also preventive and promotive functions."

The early literature in international experiences emphasised the role of the VHW as not only (and not even primarily) a health care provider, but also as an advocate for the community and an agent of social change, functioning as a community mouthpiece to fight against inequities and advocating community rights and needs to government structures. Sanders (1985: 208) summarised that "this ideal, the liberating potential of the VHW, the people's representative, is quite the opposite of the negative potential of many health professionals who transmit the idea that social conditions causing ill health are natural and unchangeable and that any solutions rest with the individual".

Examples of VHW initiatives in Africa driven by this rationale include Tanzania's and Zimbabwe's VHW programmes in its early phase. Both were set in the political context of wholesale systemic transformation (decolonisation and the Ujamaa movement in Tanzania, and the liberation struggle in Zimbabwe), and both focused on self-reliance, rural development and the eradication of poverty and societal inequities. There is a significant body of international experience and evidence (see box below), gathered over 30 years of experimentation, which demonstrates the potential of CHWs as one of the most cost-effective strategies to improve a range of primary health and nutrition outcomes.[5]

BANGLADESH

Bangladesh Rural Action Committee's (BRAC) community health volunteers called Shastho Shebikas (SSs) play a critical role in many health care program components. All SSs are members of BRAC's Village Organisations (VO) and each SS is assigned for about 300 households. The SSs provide health education, sell essential health commodities, treat basic ailments, collect basic health information and refer patients to health centres when necessary. Though the SSs work on voluntary basis, they are able to earn some money through selling of essential health commodities. The SSs also provide assistance to the government health initiatives. They distribute vitamin, organise satellite clinics. They also identify and mobilise targeted children and pregnant women for immunisation and assist in the management of government immunisation centres and satellite clinics. In recent years, a cadre of female community health paramedics, called *Shastho Karmis* (SKs), have been recruited and trained to strengthen work of the SSs. In addition to monitoring of the targeted households and providing pregnancy-related care, each SK supervises ten SSs. The SKs conduct health education meetings in the community, where health topics such as immunisation, family planning methods or sanitation installation are addressed. They maintain coordination with government health and family planning workers at the community level.

THAILAND

The Ministry of Public Health in Thailand recruits nurses, midwives, junior sanitarians, and other paramedics and trains them locally in nursing and public health colleges around the country. It then assigns them placements in their hometowns on graduation, and licenses them for service in the public sector alone. All this has helped to create a strong core of local health workers in the country.

Thailand's local recruiting efforts have been mostly positive, showing how countries can address the inequitable distribution of health workers. But to have the greatest impact, rural recruitment programs must be in a wider context of support for rural health personnel. That means improving rural health infrastructure, offering access to training and career advancement opportunities to rural workers, providing attractive incentives, including hardship allowances for rural service, and perhaps most important, making a long-term political commitment to supporting health workers and investing in the national public health care system. Recruiting locally is the most important first step.

BRAZIL

In Brazil community health agents, created by the ministry of health to address the primary health care needs of marginal populations, care for 93 million people across the country. Community health agents, local residents in the areas in which they work, cover 150 families in rural areas or 250 families in urban areas. Instructors or supervisors are most often nurses that reside in the local community who coach and provide technical support to them.

COSTA RICA

Costa Rica's Basic Health Attention Teams have revitalised the country's primary health care system and reduced disparities in coverage between urban and rural populations. The programme has shaped new referrals. Located in small clinics or peripheral facilities in the country's 90 health areas, teams are responsible for a community's physical and social needs. Each team, with a doctor, nurse, and technician, is responsible for around 4,000 people. Never alone, the workers are always backed by the supervision, technical support, and drugs and supplies of team systems. The community workers identify individuals and families at risk, provide home care for certain illnesses, and provide referrals to second- and third-level facilities.

CHW programmes have shown that "they can effect major changes in mortality and other indices of health status and that in certain communities they can satisfy prominent health care needs which cannot realistically be met by other means".[6] In a definitive survey of CHWs in many countries, Frankel (1992) confirms the enormous potential of CHWs to meet the health needs of underserved populations, but also establishes that many programmes have not done as well as was expected.

EXPERIENCE OF COMMUNITY HEALTH PROGRAMMES IN INDIA

GOVERNMENT PROGRAMMES

In India, the first major programme was the Community Health Worker Programme of 1977, whose name was changed to **Community Health Volunteer** Programme soon after and then again in the year 1983 the name was further revised to the **Village Health Guide** Scheme. This programme was taken up by most states but after a number of years, the programme was assessed as having done poorly and attention shifted away from these and in due course they were given up.

Another major government programme, initiated in the recent past was the **Jan Swasthya Rakshak (JSR)** Programme in the state of Madhya Pradesh. This programme aimed to get one volunteer providing minimum curative care services established in all villages of Madhya Pradesh. The volunteer was to be allowed prescription of drugs and also charging of user fees. These aims were met, but with this design other expectations of the JSR, especially in preventive and promotive roles and even in facilitation of government provided health care services, were not met. Its impact on health indicators was evaluated to be low and it was widely seen to have promoted a new cadre of private health care providers with little quality and no regulation. Ownership and awareness in the community of these workers was minimal.

NGO PROGRAMMES

On the other hand there have been a number of programmes conducted by NGOs usually in about 40 to 100 villages each. Many of these have done very well.

Some of the pioneer programmes that have defined this community health worker approach in the non-governmental sector are:

	Venue/Name of the Project	Organisation and key resource person associated with it	Approximate project size
1.	Comprehensive Rural Health Programme-Jamkhed, Aurangabad district, Maharashtra	Dr. Mabelle and Dr. Rajnikant Arole.	100 villages
2.	Comprehensive Rural Health Project Mandwa & Parinche, Maharashtra	Dr. N. H. Antia, Foundation for Research in Community Health.	30 villages
3.	SEWA - Rural, Bharuch, Gujarat	Society for Education Welfare and Action - Rural. Dr. Anil and Lata Desai.	35,000 population
4.	RUHSA project, Vellore district, Tamilnadu	Rural Unit for Health and Social Affairs with CMC Vellore, Dr. D.S. Mukherji, Dr. Rajarathinam Abel.	84 hamlets; about 1 lakh population
5.	SEARCH project, Gadchiroli district, Maharashtra	SEARCH : Drs. Rani & Abhay Bang.	Overall 102 villages
6.	KEM Rural Health Project	Extension service of King Edward Memorial Hospital Dr. B.J. Koyaji.	186,442 - approximately one block
7.	Vivekananda Girijana Seva Samithi, Billi Ranga hills, Karnataka	Dr. H.S. Sudarshan.	
8.	Comprehensive Labour Welfare scheme and United Planters association of Southern India, Idukki (and Tata Tea plantations. Munnar)	Dr.V. Rahmathullah.	2.5 lakhs - mainly tea garden workers
9.	Raigarh Ambikapur Health Association	Sr. Georgina; Sr. Elizabeth	150 villages, 2.5 lakh population

Of the above list the first six are important because they have generated substantial data to show the improvements in health status and much of this has been published in internationally peer reviewed journals. The other projects listed have important innovations or situations that are worth studying closely, though they have not focused on such data. There are many more projects which we have not listed above e.g. CHDP, Pachod, the Banwasi Sewa Ashram, the Deendayalu project in Chittor, AWARE programme in Naydupeta of Andhra Pradesh etc. The list above is only indicative and not exhaustive.

ESSENTIAL FEATURES FOR SUCCESS IN COMMUNITY HEALTH WORKER PROGRAMMES

The general pattern therefore in India was that large scale government programmes for CHWs tended to do poorly, while small scale non-government programmes did well.

Examining the differences between the successful programmes and those that did not do well, the following features appear having been essential to the success of the NGO organised CHW programmes in India:

a. The volunteers were women.
b. The volunteers were selected by the community guided by the NGO leadership.
c. The volunteers received continuous training and support for many years together. A one-time training programme at the outset – however long – is not a substitute to sustained training and subsequent ongoing support.
d. The programmes had curative care as an essential element, but it was not the central or only element of the volunteer's activities.
e. All these NGO programmes saw this as an opportunity to empower communities to take care of their own health and this was to spread to other spheres. Government programmes in contrast either focused only on assistance to service delivery
f. A motivated, capable, often highly qualified leadership was available to take forward the programme in the right spirit in these NGO programmes
g. There was good quality referral support available for the volunteer. Usually there was a good base hospital managed by dedicated doctors who managed the cases that the volunteer could not handle and even acted as trainers to the volunteers. Even the fact that the volunteer helped people access quality secondary care helped them gain acceptance.
h. The projects had enough time and flexibility to go through a learning curve and their doing well is apparent only after 5 years or more. Many of the projects had functioned intensively in a small cluster of villages for over ten years before they were recorded as successful.

It is now recognised from experience all over the world that these above features are essential features of any successful community health worker programme. For a number of reasons the large scale government run programmes in India had very few or none of these features. These programmes tended to be of mostly male workers, and the training was an initial affair with no provision for follow up training. The leadership was not

handpicked – the programme was given over the officer or employee in charge of the section to which this work was designated. Referral support was also very poor. In most cases the selection was either delegated to the Panchayat or to the health employee. And those selecting or supporting the CHW saw the role of the CHW as merely a link worker, not as an agent of change. About the only point where there was consensus was in medical care being an essential component.

Eight essential features of Success:

1. Women as CHWs
2. Selection by community
3. Continuous training and support.
4. Curative care essential, but not only element.
5. Part of empowerment process.
6. Carefully selected motivate leadership.
7. Good quality referral support.
8. Needs to be sustained and built upon– more than 5 years- before results become apparent.

Discussion

It is difficult to understand why the government designs did not learn from Indian and international experiences and use the essential features of NGO CHW programmes for their design. What were the pressures that led to CHWs becoming male workers? Why was there no provision for continued training? Why was selection merely left to the Panchayat head or to the ANM? Why did so many CHWs become private health care providers with very little link to public health or to public health programmes?

These are indeed difficult questions. Perhaps if we approach these with a different set of questions about the varied expectations that different stakeholders have of a CHW programme, we can perhaps understand this better.

- What do political leaders often expect out of a massive CHW programme?
- What do health department officials expect from a CHW programme?
- What do NGOs involved in service delivery expect from a CHW programme?
- What would a Panchayat sarpanch expect from a CHW programme?
- What would people in a village – especially the weaker sections – expect from a CHW programme?
- What have international and national programme planners of CHW programmes expected from CHW programmes and how does this match with the above five expectations?

At the very least, we need to note that every stakeholder has some expectations that all stakeholders have, and some expectations that only he/she prioritises.

COMPULSIONS FOR STARTING CHW PROGRAMMES

The interesting fact is that though large scale programmes did poorly, there were repeated and fresh attempts at trying out other large scale CHW programmes. Why did the programmes keep coming back? Different decision makers had different expectations of this programme.

The compulsions for a CHW programme, in government perception, came from the dispersed nature of the population in rural areas- making it impossible for an ANM to reach to all the hamlets promptly. Some other link worker was required. Utilisation of the programmes was poor and the community remained distant from the services on offer – especially immunisation, sterilisation and some of the disease control programmes – thus requiring a volunteer/link worker to help close the gap.

Political support for the programme had many reasons. One reason was the potential opportunities for 'patronage' that the programme gave. Youth who became community health workers or Jan Swasthya Rakshaks would often have either hopes of getting regular employment at a later time, or, more frequently, just wanted to learn a trade with which they could earn a livelihood. Quite a few of these CHWs and JSRs set up as 'RMPs', and began purveying medicines quite indiscriminately. Setting up such a worker in every village everywhere seemed to be a popular thing to do, to respond to the feeling of no medical care being available in the village.

Meanwhile many NGOs who were active in community health see in the CHW programme an opportunity for both improving health status amongst the poor and for leading on to the organisation and empowerment of weaker sections including women. Their persistence with this demand and the demonstrative effects of the progress in their villages, helped keep CHW on the agenda in health sector planning.

Let us look at the case of one specific programme to look at aspects of innovating at scale for community health worker programmes.

MITANIN PROGRAMME, CHHATTISGARH

In 2002, yet another attempt at a large scale community health volunteer programme was initiated in the newly created state of Chhattisgarh. It was obvious that the NGOs available in the state, who already had the experience and the capability, would be able to reach out only to about 14 blocks out of 146 in the state. It had to be the government that led the programme and even if NGOs were recruited to help, they had to be assisted and supported in the same way that the government teams had to be supported.

Consciously learning from the experience of both the earlier large scale programmes and the smaller NGO programmes, the Mitanin programme built in some of the features elucidated above. The Programme design planned for all volunteers to be women, to be selected by the community, and to receive continuous training and support. However it noted that scaling up a programme model from a maximum of about 100 villages to over 20,000 villages and 60,000 hamlets could not be done without some serious rethinking on some of the basic features.

In small programmes a leading motivated person is able to keep directly in touch with health volunteers and encourage them, support them when they need it, keep changing strategies as and when required, supervise training personally and ensure that the quality of every step is of desired levels before the next step is taken.

In contrast in a large government-run programme, the programme has to be operationalised with whatever people are available, and that means varied levels of motivation and capabilities at all levels. Thus far greater attention needs to be paid to careful designing of training, monitoring and support strategies such that they would work if guidelines are reasonably well followed even with less capacity and motivation.

The Mitanin Programme therefore made the following important innovations as necessary for scaling up the programme under government leadership

a. **Facilitated Community Selection:** The principle was maintained that selection is by the community. But to ensure that this was followed with some understanding, a process of selection was laid down where specially selected facilitators ensured that the community made an informed choice and that the voices of weaker sections were heard in this process. Without such guidelines, choice by the community often degenerated into the head of the Panchayat or dominant sections of the Panchayat making their own choice – unilaterally or with consultation of the health employee. The details of such selection processes are given in a subsequent lesson.

b. **Hamlet as Unit.** Since it was difficult to ensure representation for weaker sections even after facilitation and since the village in tribal areas were so widely dispersed geographically the Mitanin was selected for each habitation or hamlet and NOT with a village as the unit. Hamlets tend to be homogenous and created out of a need that a particular community (marginalised or otherwise) were pushed to or over generations willingly created (i.e tribal hamlets are created out of tribal cultural distinctions). Thus the fact that an average Mitanin had anywhere from 250 to 500 population to cover led to more intensive coverage and since the work load came down with a smaller population, voluntarism was possible.

c. **Curative care was supplemental** and introduced later and was not central to the programme. There were many reasons for this:

i. Given the prevailing culture of a "pill for every ill", the introduction of drugs early in the process meant that the population expected and saw the volunteer as someone providing drugs. All other messages got much lesser priority. The volunteer herself saw her primary role as dispensing drugs and felt quite useless if there were no drugs with her. If there was a strong support this could be countered. But in a state-wide programme, the leadership to counter the dominant culture is just not available in most places. We note that even small scale programmes ran the risk of only drug provision programmes- but in large scale programmes this would become inevitable if introduced at the outset.

ii. Many of the CHWs and Jan Swasthya Rakshaks of earlier programme set up as RMPs – or informal and illegal curative care providers. Many joined the programme as volunteers since they saw it as an opportunity to learn a trade. The problem is that these RMPs are driven by the market and tend to give costly drugs for self limiting illness that need no drugs and either refer unnecessarily or mistreat those conditions which they could have helped. Pharmaceutical companies also use them as a channel for propagating an 'irrational' use of drugs in their approach to curing people. Soon all preventive and promotive aspects disappear and only the curative care remains. By building in a strong message on rational drug use, by introducing curative care as a supplement to other activities, and by providing Mitanins with a better quality of support and a drug kit supplied by the public health system, the Mitanin programme successfully avoided this fate.

iii. Many small NGO programmes become examples of private sector care provision working parallel to and substituting for state action. This did not happen to the Mitanin programme. The Mitanin programme also made drugs available to the Mitanins – thereby limiting the drugs they used to those they had been trained on, and eliminating any pressure to prescribe drugs. Thus the CHW became a hamlet level, community controlled extension of the public health system, instead of becoming an expansion and penetration of unregulated private sector.

> "Almost no Mitanins have become RMPs"

d. **No Honorarium or Financial Incentive** was paid to the CHWs in the first three years of the programme. (See box at the end of the chapter on this.)

e. **The Training Strategy** had necessarily to be **cascade training**. Also given the complete lack of skilled manpower to provide training **a new cadre of trainers** had to be created and supported. Both of these are in escapable consequences of a scaling up in a context of low availability of human resources. The details of these are given in some detail in a subsequent lesson.

f. **The Monitoring Strategy** needed a set of indicators that were useful, objective and reliable. Also it needed a well delineated strategy with a clear allocation of roles and tasks – so that a programme management could identify areas where the programme was not doing well and initiate corrective action.This takes a lot of careful programme design. In a small programme a motivated leadership can with personally observe every village and with great flexibility and individualisation undertake specific corrective. But in a scaled up programme a system needs to be devised and to do so while retaining flexibility was a challenge.This is described in some detail in a subsequent lesson.

g. **Programme Management Structures with State Civil Society Partnership**: The structure of programme management and the processes by which a management structure emerges is also an aspect of central relevance.The central issue is the question of how to get the most motivated leadership which understands and agrees to a concept of CHW programmes as a vehicle of people's empowerment. One key approach was to aim for a state-civil society partnership at every level. At the state level this was represented by the State Health Resource Center and a State Advisory Committee. At the district level and block level NGOs were allotted entire blocks or they were" contracted in" to partner and assist the government leadership in providing leadership for the programme. The understanding was neither 'parceling' the programme away to a number of NGOs or undertaking it all by the government alone was as good as a programme done together in such a way that the strengths of both were available.

h. **Strengthening Public Health System in parallel and the Health Rights dimension**: The Mitanin Programme went hand in hand with an active programme of strengthening the public health system to provide referral support to the Mitanin. Indeed one of the main objectives of the Mitanin programme was to increase utilisation of public health services. Much of the activities needed to strengthen public health system had to happen in parallel – through creation of more facilities, through filling of vacancies, through creation of infrastructure, through well designed training programmes, through increasing drugs and supplies procurement, and so many other steps.The Mitanin programmes role was to draw public attention at the popular level to the gaps of the public health system and thereby increase its accountability at the local level, and to make public expenditure on health more of a political priority at the state level. The Mitanin programme addressed awareness of access to health care services as an entitlement- as a basic human right. This is critical to improving accountability and thereby the functionality of the public health system and its utilisation. The need to improve referral support for the Mitanin thus became an idiom for improving the public health system itself.

OUTCOMES OF THE MITANIN PROGRAMME

The Mitanin Programme has been able to meet reasonable expectations. Thus monitoring reports and evaluation show:

➢ That there is a trained Mitanin in almost every hamlet – over 60,000 in all.

- That there is a system of continuous training which is currently planned to last for at least five more years (three years having been completed). Mitanins continue to work voluntarily and continue to attend this periodic training with less than 10% drop outs annually

- That there have been mechanisms and support built in and these are in place as the programme is in its third year.

- That the Mitanins are equipped with drug kits and there is a system to refill it.

- That knowledge and skill levels continue to improve systematically as the training proceeds and at each level of skill acquisition there is a certain level of functionality achieved.

- That a number of processes related to women's empowerment and realisation of health as a basic right have been established, though these would have to be sustained for impact to be more visible. However already in some indicators like number of Mitanins elected to hold Panchayat office the programme has done well.

- That on a number of key outcome parameters, Mitanins are functional though this functionality varies between blocks and is sensitive to the quality of block level programme leadership.

- That given current trends if the programme persists and keeps to the basic conditions of success impact on health indicators would be visible at the state level. This effect would be much more dramatic to the extent that this it is combined with strengthening public health systems.

- That SRS data for Chhattisgarh has shown an unprecedented and rather dramatic drop in the rural infant mortality rate in the first year of the programme – from 77 to 61 per thousand in the year 2004 and at least a fair part of this drop could be related to the Mitanin programme. Though this is not conclusive – it is certainly hopeful. The UNICEF coverage evaluation survey of year 2005- 06 also shows significant improvement in Mitanin related outcomes – like early initiation of breastfeeding.

The ASHA Programme

This was started under the auspices of the National Rural Health Mission (NRHM) and is one of the most important programmes of the mission. Though the programme was initiated as an independent initiative under the NRHM with many features different from the Mitanin Programme, as the programme expands more and more changes make it very similar to the Mitanin programme.

The NRHM programme design for ASHA has the following key design features.

1. The Roles and Responsibilities of ASHA are clearly defined. They are:

   a. Create awareness and provide information to the community on determinants of health, existing health services and their timely utilisation,
   b. Counsel women on all aspects of care in pregnancy and contraception and Reproductive Tract Infections and in care of the young child,
   c. Mobilise the community and facilitate their accessing health and health related services,
   d. Work with the Village Health and Sanitation Committee of the Gram Panchayat to develop a comprehensive village health plan,
   e. Arrange escort or accompany pregnant women and sick children requiring institutional care to nearest health facility equipped to provide it,
   f. Provide primary medical care for minor ailments; also a DOTS provider,
   g. Act as a depot holder,
   h. Upgrade her to providing newborn care and management of childhood illness,
   i. Inform about births and deaths in he village and unusual health related events like disease outbreaks,
   j. Promote construction of household toilets.

2. Clear set of guidelines for selection of ASHA were put in place which was in line with learnings derived from all CHW programmes:

   a. Selection would be by the community and it would be facilitated in a planned way.
   b. There would be one ASHA per 1000 population- but can be relaxed to one ASHA per habitation where this is necessary, especially in tribal, hilly and desert areas.
   c. ASHA must be a woman.
   d. ASHA must be a resident of the village.
   e. ASHA should have communication skills, leadership qualities and be able to reach out to the community.
   f. ASHA should be literate with formal education up to 8th class. This may be relaxed only if no suitable person with this qualification is available.
   g. There should be adequate representation for disadvantaged community

3. Time line: The programme would have a Block and District wise phased roll out. But in three years time EAG states would be covered in their entirety.

4. ASHAs functions would be integrated with the ANM and the AWW and supplement but neither substitute nor duplicate their functions.

5. Training would include:

   a. 23 days of induction training spread over a period of 12 months. *(Note: it has been recommended that the first round of training may be 7 days, to be followed by another 4 rounds, each lasting 4 days to complete induction training).*
   b. Periodic retraining at least 12 days a year. (2 days once every alternative month)
   c. On the job training.
   d. Training strategy would use a cascade model of training.

6. Compensation to ASHA:

   - She would be a volunteer.
   - She would get compensation for loss of livelihood on days when she has to work full time – like attending training camps and attending monthly meetings.
   - She would get incentives linked to national programmes like for working as DOTS provider.
   - The untied fund of Rs. 10,000 can be used at the Sub-centre level as monetary compensation to ASHA for achieving these key processes.
   - There is an expectation that an ASHA would be able to earn on an average about Rs. 1000 per month from all performance based incentives and compensation amounts taken together.

7. Drug kit with basic drugs would be given by the public health system and she would dispense these drugs free of cost.

8. There would be emphasis given to social mobilisation and making this a form of community participation.

9. A budgetary provision of Rs. 7,000 to Rs. 10,000 per ASHA per year would be made till the year 2012.

AREAS OF EVOLVING PROGRAMME DESIGN

During the design of the ASHA programme though many of the essential features of the CHW programmes were incorporated, there was considerable discussion on certain specific features. We list four of these features below:

1. Is a 1 per 1000 criteria desirable? Or should the criteria be 1 per 500 or 1 per habitation?

Current Conclusion: Let us keep to the 1 per 1000 criteria since only then will an ASHA have the case load to be able to earn adequate financial incentive. However where needed especially in tribal areas and hilly areas, a specific exemption may be made.

Suggestion: Re-assess as to whether an earning of Rs. 1000 per ASHA is likely to be reached with her workload as against the advantages of many hamlet based ASHAs. Meanwhile make use of the exemption where applicable.

2. Is an educational level of minimum 8th class essential? It was considered by some experts that if this insistence is not made then the ASHA does not learn adequately and therefore the programme would fail. On the other hand the experience from the Mitanin Programme was that if the community is given only guidelines – fluent literacy – and not a rule, then in most cases it chooses a literate woman except where there is either no literate women available, or that the literate woman is not suitable while another woman with less education but more motivation and skills is available. This occurs in less than 15% of Mitanins and in these situations the communities' choice seems to be correct. With some special attention it is possible to train them and in the given context they would be more effective because they are community selected and supported than the more educated woman.

The NRHM now gives the flexibility to use this as a guideline and not insist on it where there are local reasons for the community to make a different choice.

3. Is a training cadre envisaged? It has not been stated very explicitly in the initial Mission Document, but the budget and scheme now provides for one facilitator/trainer per 20 ASHAs with adequate fund support. The challenge is to recruit them through a field based process.

4. Management Structure: This was also not clarified in the first Mission Document. Now it is clearly understood that a full time programme management structure and with mentoring group where civil society can provide partnership – both need to be created.

Guidelines Not Rules

One important aspect to note is that the ASHA guidelines can be modified at the state level in consultation with mentoring groups and the central government. These are not rules – they are only guidelines and they need to be locally adapted. The current problem is that the tendency is either to mechanically follow a standard model or make arbitrary changes without a due process and reasoning. ASHA programme requires much more innovations for it to do well. It is a difficult programme where failure is easy. Success requires a stringent set of conditions of which local adaptation is one of the most important.

Contemporary Debate: The Issue of Honorarium and its Relationship to Motivation

One of the most divisive issues of the ASHA design (and of the Mitanin Programme at its onset) was the issue of honorarium. We will discuss this issue with some examples, and once again look at the details of the Mitanin programme and its approach to the issue.

Most NGO-led community health worker programmes always had a modest honorarium for its CHWs. So had government programmes. The original CHW programme planned for Rs. 600 a year (in the late 1970s) and the JSR programme gave a training stipend of about Rs. 3000 for six months. Recent versions of the CHW programme run by NGOs propose that drugs can be provided to CHWs who can sell these with a small mark-up to provide her with some compensation. The JSR programme on the other hand implicitly encouraged charging fees for the services provided, in order to provide remuneration for the volunteers' work. But as we described earlier, in the context of the unregulated private sector and dominating culture of irrational use of medicine it led rapidly into the worst forms of quackery.

The Mitanin programme does not provide for any honorarium whatsoever. After the first year there is an understanding that for each day of training a livelihood compensation loss of Rs. 50 per day, or Rs. 100 for two days of training every month shall be paid, but nothing beyond that. Her participation is sustained only by motivation and support.

Yet the question remains: Can the programme be run without compensating the ASHA for her work? And close on its heels is another question: even if we can, is it fair to do so? Indeed the non-provision of honorarium in the ASHA/Mitanin programme is one of the most contentious issues of the whole programme design.

The reasons for demanding that the ASHA be paid are:

i. The need to compensate for loss of livelihood,
ii. The concern that one cannot secure participation of women/volunteers without monetary compensation,
iii. The concern that even if we secure participation initially we will be unable to sustain participation of the ASHA without the motivation afforded by the monetary incentive; and that is difficult to retrain every time there is a drop out,
iv. The reasoning that when everyone else in the health system is paid it would be unfair and discriminatory not to pay this woman – the poorest in the network of workers for public health – for her services.

The considerations behind the Mitanin programme design that does not provide for any honorarium for the Mitanin are:

i. The amounts considered for payment are too meager to amount to a livelihood. If an employee cadre is required at this level for this role, the minimum consideration for a viable remuneration package is that of the ANM. Hence the suggestion of two or even 3 ANMs per Sub-centre area is welcome. The Mitanin/ASHA however does not substitute this.
ii. The introduction of a small payment would make the entire burden of work solely her task and the community would not participate to the extent that it has been envisaged. From an organiser of women and the community, from being seen as representative of community who is monitoring the health services on their behalf, paying her would make her the lowest paid employee of the department – with all its attendant consequences. The critical aspect of this programme as the central form of community participation runs the risk of being compromised.
iii. Moreover, and there is a broad consensus on this, not paying her safeguards the selection process from pressures that would otherwise be inevitable and most damaging.

A decision not to pay has to go along with some other decisions.

a) Firstly the Mitanin should not have to face any loss of livelihood on account of her participation. Only as much work must be given as may be done without loss of livelihood. Her workload is estimated at about 8-10 hours weekly or about 2-3 hours per day for 3-4 days per week. In 10 hours per week it is possible to visit everyone in 30-50 families weekly and hold 1-2 monthly hamlet level meetings. The temptation to increase her workload beyond this should be eschewed. It follows that a Mitanin per hamlet is easy to sustain on a voluntary basis – but not a Mitanin per village since the workload increases when the whole village has to be covered. However, if she is called for training, a wage loss compensation equivalent to that one day should be paid. Any other work that involves livelihood loss – like attending the immunization session, or escorting a pregnant woman to the hospital must also always be compensated. Thus if we are assuming about 20 days of training per year then the compensation amount per Mitanin would be about Rs. 1000 in a year. Again if we call them out for a full day's survey work or to attend a function, a similar compensation should be paid. Any other work that involves livelihood loss – like attending the immunization session, or escorting a pregnant woman to the hospital must also always be compensated.
b) There must be a strong programme of social mobilisation to ensure continued social/local community ownership over the programme that would provide support to the programme. She should emerge as the coordinator of such mobilization, especially of weaker sections, and grow into a greater role in decision making.

c) There must be a strong programme of continued training and support in the Mitanin programme design without which the Mitanin would not be able to sustain voluntary work in the face of so much local inertia and opposition. This training and support should be able to maintain the spirit of respecting the Mitanin as a community representative, as one articulating the voices of the weakest position and provide her encouragement to do so. If this spirit is maintained the programme sustains – otherwise it does not.

We however note that this does not exclude certain functions performed by the Mitanin which can be compensated for on a piece-rate basis as an incentive, for example, making slides for fever cases, doing a survey for incidence of blindness, monitoring a patient on anti-tuberculosis treatment etc. At present the Mitanin scheme provides for incentives under the Janani Suraksha Yojana and under the accelerated immunisation programme, but we note later that it does not make any difference to the programme.

The experience with this incentive is described in some detail in the Mitanin Analytic Documentation.

If we take a decision not to pay but do not follow up with the above three conditions it will not work. When the ASHA programme was launched, this discussion took place under different terms. The main concern was that:

a) It is unfair and discriminatory not to pay the women- and there was strong political and civil society pressure to do so.
b) It would be impossible to sustain the ASHA without financial incentive.

However respecting the problems of payment and fearful of creating another cadre that would, sooner rather than later, get unionised and regularised, the compromise solution agreed was that a 'performance-based payment system' would be put in place and the ASHA would be able to get at least Rs. 1000 per month as payment from these incentives. This was an assurance made by the Ministry. Indeed this commitment was so central that the main argument for keeping the ASHA population norm at 1 per 1000 was so that there would be enough caseload for the ASHA to earn Rs. 1000 on an average every month. However this assurance has been difficult to keep. And with this realisation, lower population norms are being permitted. The thrust to ensure adequate performance linked incentives, supplemented by allocations from the untied Sub-centre funds and other local Panchayat sources needs to be planned further and implemented better.

Motivation of the ASHA

What, if it is not money, motivates the ASHA to undertake this task? The reasons are many.

Some of the ASHAs have themselves young children and would see the opportunity as enhancing their own knowledge. Many are educated women not going to work but who seek an opportunity for using their skills and the social recognition that comes with it.

But if one has really got to explain how so many women have volunteered today, one has to accept that in the village, especially in the tribal village, the sense of community is strong and can act as a motivating factor. In such communities, social recognition and one's own desire to do service to the community can be powerful motivating factors and it is an elitist supposition that the poor would not have anyone with such motives.

This is not to say that most ASHAs would welcome a monetary incentive, but they understand the compulsions of the programme. What they seek is support in the form of continued training and visits, regular refill of their drug kits and prompt and courteous care for the people they refer to the Sub-centre or the PHC/CHC. Monetary incentive would only be a fourth priority. And the system finds it difficult to deliver even these three basic requirements.

Delivering these three basic supports that the ASHA requires, and sustaining **social mobilisation** requires substantial monetary and effort investment – a point too often easily forgotten. In its absence even monetary compensation is never adequate. The ASHA programme is not a cheap low cost alternative to ANMs. Ideally we expect the cost of drugs at about Rs. 10,000 per ASHA per year (or per habitation per year), i.e. an outlay of Rs. 600 crores annually for the 6 lakh ASHAs of the EAG states as a whole. If on the other hand we pay the ASHA (say Rs. 1000 per month) in addition to the other social mobilisation activities the sum required would increase by another Rs. 720 crores – a total of Rs. 1320 crores and the probability that we would get the outcomes we need would increase is by no means certain.

Avenues of monetary compensation that the community generates within itself were proposed and it is still possible to plan for payments by the community. However currently they are only in the realm of theory. Concrete plans for it are yet to emerge though the programme is open to the possibility and would be working towards it.

Review Questions

1. ANMs and Anganwadi workers are also health care providers who work in the community. Yet the term community health workers is not generally used for them. Why is this so? What are the features of community health workers that define it as a group distinct from the above two?
2. What are the essential features of successful CHW programmes?
3. What are the aspects of CHW programmes that must change as CHW programmes are scaled up to state level?
4. What are the key design features of the ASHA programme?
5. What are the pioneering programmes for CHWs internationally and in India?

Application Questions

1. Recount the arguments for and against payments for ASHAs. There are many who argue for a fixed salary to be paid to ASHAs. There are many who argue against an honorarium of any sort or at best only a financial incentive linked to some tasks. What is your position? What are the main reasons for an opposite position?
2. The launch of major CHW initiatives or even proposals have been linked to historical forces. Are there any such larger social or political factors behind the current launch of the ASHA programme?

Project Work

1. Attend an ASHA meeting. After a group discussion, note down their expectations, their motivating factors and the work they are actually executing as different from what is defined in the ASHA text. Find out how much on an average they have earned in the last three months. What is the way forward?
2. Attend the nearest NGO run community health worker programme. Try to visit it. Find out its strengths and weaknesses. What can ASHA programme learn from this NGO led small scale programme?

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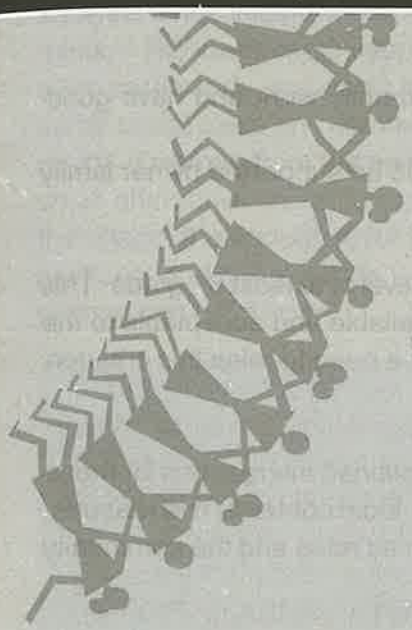
1. A vivid image and description of the CHW came from David Werner's path breaking book —Where There is No Doctor (Werner 1977). T his book, translated in 80 languages the world over has been the bible of community health worker programmes.
2. Bose, Ashish (1983):'Evolution of Health Policy in India' in Ashish Bose & P.B. Desai (eds.), *Studies in Social Dynamics of Primary Health Care*, Hindustan Publishing House, Delhi.
3. Mahatma Gandhi himself espoused the idea of a home and village doctor. On his suggestion, a comprehensive book for village m edical practitioners was prepared. This book, first published in 1940 by Khadi Pratisthan, carried many chapters that are broadly the domains of health and heath care even today: medical care, sanitation, hygiene, control of epidemics, Ayurveda and herbal medicines, women's health etc. Gandhi wrote a preface to t his book and espoused educated people to study this book and go and practice in villages (Das Gupta 1940). The Sokhay Committee in 1939 also recommended a health worker for every thousand population.
4. Shrivastava Committee Report, 1975:261
5. For a review of the effectiveness of different CHW programmes in Africa, see Lehmann, Uta et al., (2004): "Review of the Utilisation and Effectiveness of Community Health Workers in Africa", Joint Learning Initiative. In the context of Asia, especially Thailand's experience in improving maternal and child nutrition, see Tontisirin, Kraisid and Gillespie, Stuart (1999):'Linking Community Based Programmes and Service Delivery for Improving Maternal and Child Nutrition' in *Asian Development Review*, Vol. 17, Nos. 1 & 2, pp 33-65.
6. Khassy, Taylor & Berman (1998): *Public Health in Action: Community Health Workers: The Way Forward* , World Health Organisation, Geneva.

NOTES

Lesson THREE

Selection of the ASHA



In this lesson we shall discuss:

- The criteria of 'choice' and 'selection' of a community health worker with reference to the ASHA programme.
- The usual errors that occur when a large scale programme merely declares "to leave it to the community to decide"
- The possible ways of facilitating an informed and appropriate choice by the community in a large scale programme.
- The pitfalls of facilitation and guarding against these.

CRITERIA OF CHOICE FOR ASHA

To the community, clear guidelines are to be issued on the qualifications for an ASHA. These are:

(1) The ASHA has to be a woman.
(2) Preferably the ASHA should have some past experience in community work and have good communication skills and motivation.
(3) She should be able to give some of her time for her work and should be supported by her family in doing so.
(4) She should be residing in the village/hamlet and preferably married.
(5) She should preferably be an educated woman having an education level of at least 8th grade. This should be keeping in perspective if such an educated woman is available and acceptable to the community, because we want someone with fluent literacy. If there is a need to relax this criterion then it can be decided locally.

Of the above five criteria only (1) is mandatory. The community has to be explained the reasons for these criteria and then they, the community, can choose to overrule a criterion for local contexts. The reasons for these "desirable" criteria need to be explained, so that they are not seen as rules and the community can overrule one of these desirable criteria if it needs to do so:

Past work in community service: was a useful criterion to keep on the instruction book. In practice it led to many women from self help groups coming in which was one of the community services most widely available. It also helped communities to promote a better candidate against pressure from the local elite for a candidate obedient to them. It also built on the past experience of the woman and her social relation with the community.

Time availability was an important criterion: What it meant was really that the family (husband or mother–in law in most cases) was supportive and willing to take care of household chores and looking after the children etc when the woman undertook this work. Or that for other family reasons – like not having a child or being a widow she could spare the time for this work. In some cases more affluent sections were facilitated by this clause – but not to the detriment of the programme.

Married Woman: The reason for preferring a married woman was primarily because she is more familiar with key issues of women's health especially related to child birth and child care and can act as a senior peer for her main beneficiaries. Also at the field level the more convincing reason is that the unmarried woman would go away or otherwise stop working after marriage- but choose a married woman and she would stay. *"Gaon kee bahu ko chuniye, gaon kee beti ko nahin"* - though rather unfair to the village's daughters became the field level slogan of selection.

Fluent Literacy: The reason for preferring literacy is that it makes for the ability to read the guidebooks and take notes in training camps. However in many villages the few women who are literate may be from the larger landholding upper caste families and they may not be the best persons to counsel the poorest sections of the village. Moreover such women often have some caste stereotypes and prejudices in their minds – like lower caste people are less clean and do not know or bother to be clean etc. and this makes them particularly unsuitable for this job. As far as possible the effort should be to have the ASHA from the same social class and community. If there is a choice to be made in a mixed village it would be better to go for a woman from the weaker community as that is where the health problems are more. Also it is a small affirmative action to reach the weaker and more disadvantaged group. All this is not explained to the village- it is enough to tell the village that it is more important that the woman must be acceptable to all sections- and if the literate woman is not the most acceptable then a less literate or even non –literate woman can be chosen.

In Chhattisgarh a sample survey of 60,000 ASHAs (called Mitanin there) from 25 blocks showed that despite not insisting on education as many as 82% of all ASHAs were literate. The evidence is that given the choice in most villages the community understands the advantage of literacy and tends always to choose its literate woman – only making exceptions where there is a clear need to do so. Thus in a district like Dantewada where female literacy stood at 11% in the year 2002 obviously there were many villages where there was not a single literate woman and not surprisingly over 80% of ASHAs in these blocks were illiterate. But in most districts the reverse was the case with over 80 to 90% of selected ASHAs being literate, some of them even graduates!!

Lesson: Promote the selection of 8th class educated women as ASHAs – but do not insist on it – let the community decide.

The important thing to note is that except for being a woman – none of the other clauses is seen as a government rule. They were only guidelines and suggestions that the informed community could over rule, where it had a reason to do so.

Who selects the ASHA? The Route to Discovery

Selection of the ASHA was to be by the community that she had to serve- or as we would like to put it – the community whose action the ASHA would have to facilitate or lead. During the formulation debates of ASHA many were to argue that beyond stating it thus... "Let the community decide" – no further guidelines are to be issued. No person should 'intermediate' the community's choice – for that would always be interference in the community's choice. This 'leave it to the community' approach often leads to some typical errors.

In District A, the district collector informed block Panchayat officers about the criteria and conveyed this information to the Panchayat heads at all levels. The instruction sheets they used contained an adequate description of the programme- but as the message traveled down the chain the only message that got through was to "select the bahu and not the beti" of the village. Therefore Panchayat chiefs in most cases nominated a name, and despite being told that the programme was voluntary, often nominated a person close to themselves or to whose family they needed to extend patronage. Even where they chose keeping the village's interest in mind, the lack of tradition of any democratic and collective decision making, and their lack of insight into the programme and task, led them into a nomination exercise where often even the person being nominated was not informed - or informed only that their name was being sent in for a possible government job. Obviously there was very little satisfaction even within the health department with the lists that emerged.

In District C, a circular was issued stating that the ANMs or MPWs would be responsible to see that the selection was completed in time, and that Rs 150 would be paid for each ASHA selected. This "Rs 150 per ASHA selected" was indeed a rule of thumb budgetary provision that had been made for the selection of ASHA's in the ASHA programme budget. It was meant to undertake a number of activities like holding meetings in each hamlet and the cost of the facilitator traveling to the hamlet for this purpose etc. and certainly not meant to be paid on a per ASHA basis. Predictably, in a month the lists of the ASHAs selected for every hamlet had come in. Mostly they had been nominated by ANMs and since they were to be paid Rs 150 per ASHA, many more nominations were made than had been envisaged. Most sections in the department were quite satisfied with the selection process (some to this day) and it was difficult to make a case for any alternative selection process, more so that now the selection had been completed. It turned out that many ANMs and MPWs had promised the ASHA that she would get at least Rs. 1000 per month from performance based incentives and many joined with this hope. Of course once the training started and it became clear that there were going to be no honorarium, there were plenty of dropouts and the selection had to be done again. This time community processes were put in place.

Discussion

The above two case studies are from Chhattisgarh in the year 2002. Subsequently the selection was redone in these districts.

Do a small study of ASHA selection in the place nearest to you where the programme is on. Interview a number of ASHAs and some of the people in the village and find out how selection was undertaken. Find out what were the instructions issued from the state level. Match the two. What is your learning? In case you find that the selection is like in the case studies - Is it that the instruction issued was correct and that it was not followed correctly? Or that the instruction itself was wrong? Or that though the instruction is correct given the nature of the system through which it has to be implemented, the end result is necessarily going to be wrong and the instructions did not take precautions against such errors?

Facilitated Selection: One Possible Approach

It is therefore advised that selection by the community be seen not as an appeal to be made – but as a clear set of monitorable processes. The ASHA selection may be described as a well planned nine step process based on the experience of selection of Mitanins in Chhattisgarh.

Nine Step Selection Process:

1. Selection of Facilitators/Preraks.
2. Training of Facilitators.
3. Informing the Hamlet.
4. Mobilisation in the Hamlet.
5. Gram Sabha meeting and selection
6. Panchayat endorsement.
7. Monitoring and Troubleshooting to ensure this process.
8. Documenting the process and choice
9. First meeting of selected ASHAs

Step 1: Selection of Facilitators (called Preraks in the Mitanin programme)

The Prerak is a volunteer who is able to give some time voluntarily to perform six functions

a. to hold hamlet level meetings to inform the community about the programme and the expectation of the ASHA.
b. to conduct dialogue with different stakeholder groups to assess their choice .
c. to negotiate with more powerful privileged groups in the community to ensure that the choices of weaker sections are articulated.
d. to ensure that the choice is made after discussion by the gramsabha.
e. that the village Panchayat in writing endorses the choice made by the gramsabha.
f. that the name of the ASHA is then submitted along with documentary proof of the processes – at least a report and the signed minutes of the Panchayat meeting and if possible the minutes of endorsement of the gram sabha – at least to record those who were present there.

Selection of the Facilitators/Preraks was done by consultation amongst different stakeholder groups- ANMs, AWWs, Panchayat Sarpanches, local NGOs. In meetings with representatives of each of these groups separately or together they would be asked – we need the names of 15 to 20 persons- one from each haat area-(a haat is a village market which is linked to 10 to 15 villages and in constant social and economic touch with them) who would be willing to play the role of Prerak. He or she should be a well known person with a good experience and reputation, dedicated to social good, whose words are respected widely and who would be available to hold meetings in all these hamlets coming in that haat area. If more than one stakeholder group suggests or endorses a name usually that name is effective. In programmes contracted out to NGOs the Prerak was chosen by the organisation as one of its members. Where the organisation had a long history of work in that area this was adequate but where contract had been given to an organisation with no such roots this could be disastrous and we had to insist that they too follow the same method in selecting the Preraks. A number of MPWs and ANMs who were motivated also became Preraks – but this was about 10% of the total.

> **"The Prerak should be a well known person with a good experience and reputation, dedicated to social good, whose words are respected widely and who would be available to hold meetings in all these hamlets coming in that haat area."**

To hold these initial meetings for selecting the Prerak one needs to identify two or three persons at each district level. A five day state level training of trainers of the Prerak is thus the starting point of the entire process. Also the state level coordinating body (like the SHRC in Chhattisgarh or the Sahiyya Working Group in Jharkhand) visited every district and got the district collector (in Mitanin) and CHMO (in Sahiyya) to hold a meeting of all the various concerned departments and NGOs to explain the programme and initiate the consultations to seek their help in Prerak and later Mitanin/Sahiyya selection. At this meeting two or three district level persons would be identified as support persons who could go on to play a coordinating role. After the Preraks were selected, based upon who had been most active and supportive on the district level, their names would be advocated for being the district nodal officer for the ASHA Programme.

Step 2: Training of Facilitators (Preraks)

It was difficult to convince the system that such a training is needed. Yet if the village is to make an informed choice of an ASHA, the person carrying the information needs to have a clear grasp of the programme and all its details. Also he/she has to be able to convince the village that indeed no honorarium is to be paid- now or later. Whatever the merit of the discussion on performance based incentives and honorariums, it must be clear that if the honorarium is used as a motivation for selecting the ASHA the programme is damaged beyond repair. Training is also essential for the Prerak to gain an insight about

how relations of power vis a vis gender, caste and class work within the community. Due to historical marginalisation, discrimination, and even violence, the poor – which would include lower castes and classes, have been found not to articulate their issues, ideas and concerns in any forums, especially public forums. This is a direct outcome of the atmosphere of inequity in which they may have suffered over generations. The Prerak needs to understand that health equity and justice require affirmative action to voice the needs and participation of these weaker sections. The third crucial learning is negotiation; that after understanding the need for voicing the weaker sections' choice, one also needs to secure assent for it from the entire community including the dominant minority. Thus the Prerak has a crucial role and one requires four or five days of a very special type of training to bring this about. Though many Preraks were ANMs or AWWs, even they benefited by such training. The programme thus brought out its first guidebook as a guidebook for Prerak training.

Step 3: Informing the Hamlet

After the training the Preraks were asked to hold a number of meetings within all the hamlets to explain the programme. Both before and after the meetings they were to dialogue with various decision makers and even families to understand the village dynamics. The point to be monitored was whether the Prerak had held at least three meetings before the gram sabha that made the selection. First was an introductory meeting that helped call a larger meeting. The second was a meeting of the women. A third was the meeting after the mobilisation work and with greater awareness of the programme and in which the Prerak explained the whole programme and finally there was the gram sabha.

Step 4: Mobilisation in the Habitation

The programme also undertook a number of major mobilisational events. Most important amongst these was the Kalajatha. The Kalajatha is a traveling troupe of artistes who, using largely folk art and culture, explain the importance of the programme and its spirit. The usual performance is about two hours long has two small half an hour plays interspersed with over five or six songs. Through this device the voluntary spirit of the programme and its potential for empowerment were conveyed to the entire population. This was packaged as three key messages or slogans:

a) that people's health should be in people's hands,
b) that health and health services are a right of the people, and
c) that the ASHA is a volunteer and an activist leading the village – not the junior most employee of the government.

The ASHA programme provides funds for this but very few activists/systemic functionaries or programme managers have realised how important this social mobilisation is. In its absence very few women would

volunteer to become ASHAs and the programme would have far too little programme support from the community.The term social mobilisation is also to be used to cover the number of public meetings and the media events associated with the programme many of which included the participation of political leaders.These activities make the programme prestigious.Without them an ASHA would not have the social recognition which is essential for her voluntarism and her functioning.These also become effective and mass appealing channels of explaining the ethos of a programme to large numbers of people.

Step 5: The Gram Sabha Meeting

This seems an obvious and easy thing to do –but in the absence of a tradition of holding full gramsabhas, this can be difficult. Also women's participation in the formal gramsabha may be very limited. Thus, usually what happens is a hamlet level aam sabha – and then the decision is taken to the Panchayat.The Prerak should attend the meeting so as to ensure not only that choices of weaker sections are placed and discussed, but also that there is some effort to call all families for the meeting and use the meeting to reiterate the three main messages.Too often otherwise the meeting becomes a formality with only a few persons attending. However unless there is enough attendance and discussion the spirit of the decision that the ASHA is chosen by the gramsabha is not met.

Step 6: The Panchayat Endorsement

The Panchayat in its formal meeting must endorse the decision and record this in its minutes. It may provide a letter to the ASHA and to the programme officer subsequently.This formal endorsement in the meeting is much easier to secure where the Sarpanch and the members have been involved from the beginning and the gramsabha has taken and recorded its decision on choice of the ASHA.

Step 7: Monitoring the Process

When such an activity is declared across a whole block of over 100 to 300 villages- monitoring to ensure that these processes happen is a challenge.

Q. What not to do in monitoring?
A. Do not keep asking how many ASHAs have been selected.

Q. What to ask for effective monitoring?
A. Ask

- How many hamlets have had three meetings completed?
- How many Hamlets have had a Kalajatha programme?
- How many hamlets have had an aam sabha?
- How many hamlets have had a Panchayat meeting held formally and recorded their decision on the selection and notified it and sent a report in

- Then how many Preraks have been trained?
- How many Preraks have completed all aam sabha meetings of their hamlets- how many have completed in more than half etc?

Q. Who does the monitoring?

A. The district resource team made of two persons per district – who were also the same persons who did the Prerak training. They hold a meeting of Preraks once in two weeks and collect reports from them and ensure that they are on the job. They also visit the villages to see whether their reports match with what is happening on the ground.

Step 8: Documentation of the Choice

For a number of reasons a number of people representing different vested interests, local politicians, Sarpanches, officials, hostile evaluators etc will keep challenging the selection. It is important to protect the ASHA and the programme from such challenges. It is therefore important that two key elements of the process- the aam sabha/gramsabha meeting with a list of those who attended and the Panchayat meeting with formal signatures of those present- be documented and a copy of this documentation be kept with the programme team at the block and at the district level. This is not very useful to improve processes as they can be prepared without having the meeting in the desired spirit but they are essential to defend the programme. A letter from the Panchayat to the ASHA confirming her selection was something we had not asked for. Retrospectively many felt that this would have been useful for the ASHA to have.

Step 9: First Meeting of ASHAs

The first meeting of ASHAs held at the venue of the first training camp helped to ensure that ASHAs know what is expected of them and prepared them for the first training camp. This would be a residential camp and a new experience to both the ASHA and the family. Hence it was useful to have a meeting and inform not only the ASHAs but their family members who often came with them.

Discussion

In an ideal model the assumption is that if all the village agrees on a single 'best' person unanimously she would command the support of people subsequently. Such an unanimous choice is unusual even when the job is completely voluntary and almost impossible if payment is being expected. Different stakeholders may have different preferences and it is relations of power that would finally bring about selection. Thus a sensitised Prerak is essential to help women and marginalised sections articulate their choice in the group so that the Sarpanch or the ANM agrees. The ANM or Sarpanch may agree readily or reluctantly. If there is reluctance, the ANM and Sarpanch may take the first opportunity to support someone else. Thus when it comes to assigning a person as DOTS provider, which involves a small incentive, or giving a person incentive for identifying a blindness patient they would pass this incentive to anyone other than

the ASHA- knowing that this would de-motivate ASHA. In contrast a ASHA chosen unilaterally by an ANM may get good support from her and therefore be able eventually win more approval in the village.

So, in the event of not being able to get a consensus, is it better to have the ANM's support or the Panchayat's support with a reluctant community support or is it better to have the support of the weaker sections who are the majority and who need the help most- even if it means less support from ANM or Panchayat?

Consider the Statement : When we say "the community must decide" we implicitly are saying that it must be the choice of the weakest sections which are also the majority. Though the majority view or the weakest sections views must take into account the views of other stakeholders also and try to win their consent for this choice, the role of facilitation is to win the consent of the other stakeholders for the choice of the weaker sections of the village and not the other way around!!

Lessons to be Learnt from Experience to Date

This sort of selection was planned for in the Mitanin Programme: But did it happen as it was planned? We quote from the SHRC study. "The most common error that could occur is that the Prerak decides on behalf of the village- usually in consultation with the Panchayat or in consultation with the Govt employees- ANM/ AWW. 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 functionaries or themselves bureaucratic with little understanding of empowerment and processes required." The study also showed that the Panchayat had been involved in about 72% of the selections and that primarily the Sarpanch had made the decision in 26.5% of the ASHAs sampled. Also good selection does not automatically mean better outcomes.

Prerak facilitated programmes can end up depriving the community of choice, with state and district programme managers taking over the process. However, the evidence to date is that the greater danger is that in the absence of facilitation by a specially trained Prerak in a large state run programme, the community, especially its weaker sections, are much more excluded.

Finally there is the learning curve. By the time we had learnt how to describe the selection process much of the ASHAs had been selected. This should not matter as long as we learn from it and improve selection in the next round.

a. The Nine Step Approach to Selection as outlined above is essential to get a proper selection done in a large scale government run programme where there is no long tradition of government run programmes. The alternatives to such a process becomes in practice one of the two approaches- either the department staff making its own list or the Sarpanches making out a list based on patronage - and these really lead to programme disasters.

b. The weakness of this nine step approach is that the Prerak "takes over" and instead of assisting, replaces all the other processes and institutions- since the institutions themselves are so weak and faction ridden. By being conscious and warning against this danger and with due caution and monitoring for processes as against monitoring for number of ASHAs selected, this weakness can be offset.
c. There is a need for a body representing state-civil society partnership at the state level and where possible at the district level to monitor and guide the process. Do not leave this to only the government or merely contract it out to an NGO. Because then one or other error of selection is sure to crop up. Build a partnership organisation or body to undertake this.
d. If selections are made poorly there would be high drop-outs between training camps and re-selection becomes mandatory. This becomes an opportunity to correct the selection process. However this is costly and effort intensive. So do try and get it right the first time. But if it has not happened correctly – never fear there is always more opportunity to come provided one does not hurry to fix the ASHA in a permanent manner by needlessly issuing orders too prematurely.
e. There is no evidence that more time by itself makes for better selections. However following all nine steps listed above takes time- about three to six months on an average. If there is no person working full time on the project, completing these nine steps takes longer and leads to higher officials setting a deadline for completion of selection. Thus, there appears to be a problem of too rapid a pace when it is actually too little of person-time given to the programme. In some NGO programmes which have taken much longer for selection the results were no better because this time was not spent on selection – it was spent on other activities unrelated to this programme. This is the same in the government programmes also. Higher officials worried about slow pace of programme should try to correct it by increasing amount of (wo)manpower deployed in executing it, not be setting a time deadline. The nine steps or processes should be taken as non –negotiable- but the time taken to do it in is variable. The shorter the time taken to achieve these processes with quality- the better the pace and enthusiasm of the programme
f. Even where selections have been made by different processes,- by ANMs. AWWs, Sarpanches etc – if the selection is good enough to prevent drop outs of ASHAs then with good quality of training and support one can get reasonable outcomes. So if the selection has been already completed in your area. Do not lose hope. Intervene anyway and one can still make it a viable community health worker programme.

FAQS

Q. *But is this not too elaborate? Can we not simplify it?*
A. Good NGOs take months or years to set a community process adequate for a good selection in motion. Since time is a constraint and since in a large programme one is to build the programme through people with various levels of motivation and understanding, it is essential to define these processes. This is the absolute minimum required for a quality outcome. Those districts where

this set of processes are not adhered to should blame themselves and not the ASHA concept if it fails to take off.

Q. *But are these selection processes like inviolable laws – then why not make them compulsory rules of the scheme.*

A. These are only one illustration of how a principle – that of selection by an informed, and enthused community with negotiation to keep the interests of weaker sections protected- can be achieved in a large scale government run time bound programme. Many other variants of this are possible. For example in the Sahiyya Programme of Jharkhand the insistence is on forming village health committees. After repeated discussions the village health committee nominates an ASHA and gets it endorsed by the local governance body.This is absolutely valid as a selection process too and ensures that every one of the principles of selection is adhered to.

Q. *But such a selection through so many processes costs money and takes time.*

A. Funds are specifically provided for both selection process and associated social mobilisation which are meant to be spent on this. One has to ensure that it is so spent. And yes – one year is long enough to meet these targets if they are begun early enough. If the process is begun in the last three months – then of course time would be insufficient.

Q. *But what about the administration and monitoring costs.*

A. 6% of the costs can be booked for administration. But even this may not be enough. A regular full time state level training cum monitoring and support team with a core leadership and about one or two trainers per district is probably essential. It does not help to underestimate what it takes to deliver an outcome.

Q. *Could there be alternative approaches to facilitate selection – keeping the same principles in mind – namely ensuring that the choice of the majority who are the weaker section gets the consent of the dominant sections.*

A. Yes. The Jharkhand Sahiyya Programme has come up with an equally viable alternative. Here the Prerak organises a village womens health committee and assists it to become functional. After some time of such functioning the village womens health committee selects the ASHA (called Sahiyya in Jharkhand). The village womens health committee is made with the full participation of every section and since it is a committee the tensions between stakeholders are less. Once the committee is functional the committee can make an appropriate choice much better. The only challenge of this approach is that the task of the facilitator becomes far more challenging –as starting up a womens committee, getting it functional and assisting them to make an informed choice involves considerable effort too.

Review Questions

1. What are the essential and what are the desirable criteria for the choice of ASHA?
2. What is the role of Prerak in the facilitated selection of ASHA?
3. What are the nine key steps in selection of ASHA?
4. What are the barriers to implementing this nine step process of selection everywhere?
5. Who, by the rules, is empowered to select ASHA and whose endorsement of this selection is essential?

Application Questions

1. Why can we not leave selection to the elected Panchayat? After all they are the elected representatives of the people?
2. Facilitators/Preraks also come from some strata of society – and often they could come from dominant sections? So would creating a cadre of Preraks become an impediment to community selection rather than a help.

Project Exercises

1. Write a brief report on "What are the processes of selection followed in your district or block? Why did it happen so? What are the common errors of selection noticed in your district or block? Could you check whether there are written guidelines for proper selection and whether these are adequate. If adequate were they widely distributed and available to general public and to those involved in facilitating selection. If not arrange to distribute the corrected guidelines widely. What was the experience in doing this.
2. Could you try out such facilitated selection in a group of villages. Be the Prerak and carry out all the steps of selection? Could you write down your experience of the dynamics of such selection.

NOTES

Lesson FOUR

Training Community Health Workers in a Large Scale Programme

In this lesson we shall discuss:

- The training strategy for a large scale community health worker programme.
- Two models of a training curriculum for community health worker programme.

THE BASIC PRINCIPLES

Training is a process of building specific competencies (knowledge or skills or attitudes) in the trainee. ASHA training should lead to the development of specific competencies in the ASHA, which she needs for her functioning. For ASHA training to be successful we need to clearly spell out what these competencies are, how they would be built up in the trainee and how the programme management would be able to measure whether these competencies are indeed built up or not as was intended. For details of how to plan a training strategy and how to design a training programme please refer to Book 5.

INTRODUCTION

Any large scale CHW training programme like ASHA Training Programme has two parts:

A. **Training Curriculum:** What competencies need to be built up, (the training syllabus or training content) and how these competencies would be acquired (training methodology). Together they constitute the training curriculum.

B. **Training Strategy**. How is the training of such large numbers to be organised. How do we manage to get tens of thousands of volunteers trained not once – but again and again and again in continuity for at least the next five years!!!

TRAINING STRATEGY

Under this we shall discuss the following aspects:

a. Determinants of Training Strategy.
b. Choice of Approach: Modular nature of training
c. Types of Training: Camp based and field based training
d. Camp Based Training Details:
   i. Duration of training
   ii. Residential Nature of Training
   iii. Resource Persons
   iv. Training Materials
   v. Camp logistics.
e. On-the-Job Training
   i. Cluster Meetings
   ii. Village visits
f. The Trainer:
   i. Recruiting trainers
   ii. Getting trainers trained.
   iii. Supporting Trainers and upgrading their skills.
g. Key issues of cascade training.
   i. Quality of Key Resource Persons
   ii. Use of training Material
   iii. Use of Training Evaluation
h. Monitoring Training.
i. Costs of Training.
j. FAQs

DETERMINANTS OF TRAINING STRATEGY

The key determinants of a training strategy are:

a) The competencies that are determined as mandatory- how much to teach?
b) The time available to complete training- a compromise between what they need to know and the time that volunteers can make available to get trained.
c) The potential availability of trainers - This is a function of what pre-qualifications we insist on; what is the ability of the potential trainers to spare time and what is the ability of the programme to compensate them for the time they spend on training.
d) The degree of support/priority for the programme from decision makers.
e) The funds available.
f) An assessment (usually subjective) of the state of women volunteers' readiness/ access to such a programme.

A) How much to train and how long can training be?

Most approaches to community health worker programmes would recommend at least a 3 to 6 month training programme to achieve all the competencies needed with adequate quality.This ideal requirement has to tempered by other factors that limit the time available.

- Women from poorer sections cannot be withdrawn from their livelihoods and homes for such a long training period. If provision is made for adequate compensation of livelihood loss, then for poor communities this would amount to earnings that women may feel incentivised about. Given these factors, the entire choice of the CHW would change, if such a long training programme was made mandatory.
- Then again if there are dropouts (and there are bound to be drop outs) after the first training – the task of getting another replacement trained will pose huge burdens on human resource and expenditure.
- Where there has been dynamic leadership, available trainers with adequate capacity in adequate numbers and considerable investment made in social mobilisation, it has been possible to start with a long initial camp-based training phase . But many programmes like the Mitanin Programme, or the ASHA Programme under the NRHM, which are initiated by the state have little confidence and commitment at different levels in the initial stages, and the investment and effort needed for a large scale mobilisation at the outset of the programme is very difficult – indeed impossible to obtain. Confidence and commitment for the programme even amongst those managing and leading the programme has to be built up.
- Also if most ASHAs selected are women from weaker sections- the first three day training camp would itself be a very new social experience.

- Families of women from weaker sections can cope with their repeated short absences – but not with one long absence from their household and livelihood activities.
- Long duration training requires more experienced trainers who can keep the training interesting and intensive without making it tiresome over a long period. Such experienced trainers are not easily available in most districts and states, especially at the decentralised levels. For example, in Chhattisgarh there were many vacancies for ANMs and few ANMs within the health department could be spared full time for playing the role of trainers. Besides, the ANMs' training itself was incomplete and clinical skills needed upgrading. There was very little else qualified manpower available, either with NGOs or in the open market. The state was left with no choice but to recruit a cadre of trainers from the educated women in the villages and train them for the Mitanin Programme. In contrast, Andhra Pradesh has over 140 ANM training centers and 100 staff nursesing schools. Many of these ANMs and nurses were available for recruitment through NGOs for acting as trainers. Of course even they needed training – but their net effectiveness was more and one could carry out a more intensive 21 day initial training.

Given all these factors and without compromising on the quality standards, the ASHA training approach evolved aims for repeated short term camps providing 25 days of training interspersed with systematic on the job training, providing another 30 days of training input in one year. This is to be repeated every year with another 12 days of camp based training per year and 30 days of on the job training per year for five years. More than this would anyway be difficult to achieve.

The above factors are not considerations of all CHW programmes.

CASE STUDY 1

In Jamkhed there was an NGO running a community development programme for over three years before it decided to initiate a CHW programme. The programme had been focused on developing farmers clubs and many development programmes related to agriculture and livestock management. It also organised many women's activities . So when it came to asking a few village women to volunteer for training as CHW this could be done easily because by then both the NGO and the community were familiar with the choices available. Over six months of interaction, the families decided that they could spare the woman to attend a one month long initial training. After these women were trained and deployed then the programme went to the next group of 20 villages and so on.

CASE STUDY 2

In another instance an NGO decided to build a programme in partnership with an Adivasi rights movement which had been ongoing for a number of years in this area. Over such long standing interaction with the

community they had developed trust and understanding and the Adivasi rights movement could readily facilitate the choice of a person as a representative of weaker sections who was ready to become a CHW. She was already known for being active and was supported by her family and the community to attend a long training programme.

Discussion

What are the strengths of CHW selection by the above means? How does it facilitate their coming in for a one month long initial training camp?

What could we learn from this case study to make the first round of training longer and secure the participation of women as residential trainees in such a training camp?

In the state level context where ASHA programme is being upscaled, largely to areas with no NGO activity or pre- existing social mobilisation, this sort of CHW choice and community mobilisation is difficult to achieve. So what is the length of a training round that is possible?

CASE STUDY 3

In Chhattisgarh even as the SHRC planned a 20 day training programme over 7 rounds one NGO rushed to declare that it would make do with a 4 day training and some key messages. Many districts, under pressure to produce results, a number of women were selected , trained for 4 days and declared as Mitanins. This was done with malaria control funds and they came to be known as "Malaria Mitanins". Unable to exercise synergy with these efforts the SHRC just decided to go ahead with its approach while the others went ahead with theirs. This did create a lot of avoidable confusion in the villages, for at a time there were three types of Mitanins in some of the villages. However over a period of six months – the other Mitanins just disappeared as a confusing factor. Either they had merged with the Swasthya Mitanins or just ceased to exist.

What does this case study imply for the discussion on duration of training?

When recounting the history of the Mitanin programme or other CHW programmes there is a tendency to tell the story as if there was one golden model that was successfully designed , attempted and followed. The real picture is that in parallel, many diverse methods were tried, and over time some of these methods survived and some were given up. It is, however, equally important to know what did not survive.

b) Choice of Approach: Modular Basis and Recurrent Short Camps:

Having decided that we would aim for 20 camp days of training divided into seven rounds, the next question was how to evolve the training curriculum in accordance with this phased training programme. The choice is between taking one or more topics in each round completing it and in next training going on to the next topic. This way the order of topics can also change without affecting the programme. We call this the modular approach- where each round is a separate independent module. Or to take several topics and advance a bit of knowledge in each area, so that by the seventh round adequate knowledge has been built up in all areas.

CASE STUDY 1

The Mitanin Programme decided to go in for a modular approach. This meant that the training syllabus was packaged into seven stand alone modules and published as seven training guides.

These were:

1. *People's Health in People's Hands- An introduction to what is health and sickness, to the social determinants of health, to why people fall ill and why people to not seek health care in time and on the relationship between patriarchy and ill health.*
2. *Our Rights and Our Current Situation: This is an introduction to the health services that people are entitled to and which, at least in paper, are available in the health facilities.*
3. *Child Health: This book is on common childhood illness and what Mitanins can do to prevent child deaths.*
4. *Women's Health: This book covers the relationship between patriarchy and ill-health, care in pregnancy, adolescent health, management of anemia in women, knowledge of the reproductive systems, an introduction to management of Reproductive tract infections, and violence and women's health.*
5. *Control of Malaria and Waterborne diseases – especially epidemics*
6. *Control of tuberculosis and leprosy*
7. *The Mitanin's drug kit*
8. *The Panchayat Level Health Plan.*

The books are so organised that though the recommended order in which training was to proceed was from books 1 to 7 in the above order, at any time, for any valid reason the order could be changed. Thus many groups actually did complete the drug kit round before they completed the two modules on control of the communicable diseases. And many others began with the module on the control of malaria because an epidemic was imminent in their area.

Discussion

The decision not to break up a topic over several training rounds was also essential because:

a) there could be large time gaps between one training programme and the next and if a theme was broken up into two parts over two sessions the continuity was lost.
b) each training module was also a reference book. If all the concerned chapters were at one place – it was easier to use.
c) training and deployment were linked. After each topic was completed work on that area would start in the villages. This would not be possible if only part of a topic was covered.

In the ASHA Programme, the first book was built on the incremental approach (or rings approach), but from the second book it shifted to a modular approach. Are the reasons in favour of a modular approach applicable to your district? How essential is it to build the training module as seven books or seven modules? Why not just a single book.

Training Plan: Example of the Mitanin Programme (Case Study 1, contd ..)

The Training Plan for the first year was planned at 50 days. Of this, 20 days were to be camp-based and 30 days were to be on the job training. Camp-based training is training conducted in a class room setting with about 20 to 40 trainees and a group of 3 to 5 trainers. On-the-job training is by the trainer going with the trainee Mitanin to the houses in the village or the village meeting.

The camp-based training period of 20 days for covering these 7 books were broken into:

Training Rounds	Number of Days	Modules	Topics
Round 1	Four days	Book 1 Book 2 Book 3	Introductory perspective on health Basic health services that people were entitled Child Health
Round 2	Two days	Village Health Register Pictorial Key Messages Book	Repeat these same booksIntroduce the village health register
Round 3	Three days	Book 4	Womens Health
Round 4	Two days	Book 5 A	Control of Epidemic Disease Gastroenteritis and Malaria.
Round 5	Four days	Book 6	Mitanin Drug Kit.
Round 6	Two days	Book 5 B	On control of TB and leprosy and revision of drug kit
Round 7	Three days	Book 7	Village Health Planning

The field based, on the job training was to take place at an average of two to three days per month.

Discussion

Is there a training plan for the year evolved for your state/district ASHA programme? Can such a training plan be evolved?

CASE STUDY 2

There is a decision to scale- up the Home Based Neonatal Care Approach into the ASHA programme. Only blocks and districts where the ASHA programme has been launched and is relatively doing well would be selected. Here an intensive series of seven training workshops would be delivered over a 18 month period. Each of these seven workshops would be for four days- a total of 28 days.A training plan for ASHAs has been finalized as shown in the accompanying table.

Training Rounds & workshops	Number of Days	Topics
Round 1 Workshop 1	Four days	☞ Communication skills ☞ ARI ☞ Diarrhoea ☞ Nutrition education
Workshop 2	Four days	☞ Introduction to home based newborn care ☞ Antenatal visits ☞ Attending delivery.
Round 2 Workshop 3	Four days	☞ Care at birth(including skill for using mucous extractor) ☞ Examination of newborn ☞ Home visits
Workshop 4	Four days	☞ Breast feeding ☞ Hypothermia ☞ Health education
Workshop 5	Four days	☞ High risk neonate ☞ Detection of sepsis and treatment with oral cotrimoxazole ☞ Revision and Evaluation
Round 3 Workshop 6	Four days	☞ Asphyxia management using bag & mask ☞ Sepsis management using injection gentamicin
Workshop 2	Four days	☞ Revision ☞ Evaluation and Certification.

This above training plan needs a corresponding training strategy to roll the programme out across the state. To this end it defines a training pyramid – of state trainers, district trainers and block level mentors- the last of which is largely for on the job training. Then it defines how the different levels of the pyramid would get trained and finally it sequences it into a training schedule which we give below:

Phase One	
First Round of Training	
• Training of 20+10 trainers per state • (15 days of training: training on foundation course plus for workshop 1 & 2)	Month 1
• Training of 200 mentors per state • (15 days of training: foundation plus workshop 1 & 2)	Month 2 & 3
• Training of 2000 ASHAs+ ANMs per state (2 workshops of 4 days each with a one month gap in between :	Month 4 to 6
Second Round of Training:	
Training of 20+10 trainers per state (15 days)	Month 7
Training of 200 mentors (15 days)	Month 8
Training of ASHA second round (3 workshops)	Month 10 to 13
Third Round of Training	
Training of 20+ 10 trainers (15 days)	Month 10
Training of 200 mentors (15 days)	Month 11
Training of ASHAs (workshop 6 & 7)	Month 14 to 16
Second Phase	
Start – recruitment and deployment Half the remaining districts – four blocks each Plus all the blocks of the first phase	Month 9 of first phase or month 1 of second phase- then goes on to a 16 month cycle as described for the first phase
Third Phase	
Start – recruitment and deployment All the remaining districts – half the blocks plus all the remaining blocks of the second phase	Month 21 of the first phase or the month 1 of the third phase – and then goes on to a 16 month cycle as described for the first phase
Fourth Phase	
Start – recruitment and deployment	Month 33 of the first phase or the month 1 of the fourth phase- and then goes on to a 16 month cycle as described for first phase.

Note: This case study is an example taken from a programme on the planning stage- but it is indicative of how state level training strategy needs to be drawn up for ensuring a successful ASHA programme. This training plan and training strategy is in addition to the ASHA training plan and strategy that has already been rolled out. However since existing plan and strategy are weakly defined, it is likely that effective skill building will happen only when the HBNC dimension or some other similarly well planned and worked out training plan and strategy is included along with a viable programme structure for providing continuing monitoring and support.

ORGANISING CAMP/WORKSHOP BASED TRAINING: SOME KEY ISSUES

a. **Duration of each training round and the inter-round duration**: The duration of camp based training, as we saw earlier, varies depending on the module to be transacted. Also the principle is to have a long first round of training and for one or two key topics with shorter rounds in between. But if we make the round too long, then many women would miss one or two days of training and there is an unacceptable loss of quality.

   The gap between training programmes should be between 6 to 12 weeks. Never more. Unfortunately most government programmes like the Mitanin programme never realise this planned gap and in practice it could be even more than six months between training rounds. Usually the constraints relate to bottlenecks in the flow of funds or in the preparation and production of training material.

b. **Venue**: The deciding principle suggested is to keep it as close to hamlets as possible with a camp strength of 30-40 trainees. Thus if there were 400 Mitanins in a block, it meant providing for 10 training camps requiring 10 suitable venues. Similarly, if there are 100 ASHAs in a block it would mean 3 training camps in three towns within the block. Sometimes one venue would serve for two camps. Some blocks may consider transporting all the Mitanins to the block headquarters if other good training venues are not available. However, the costs of such transportation, and the reliance on too small a group of trainers may be tiring for the trainers and the trainees and it may be necessary to have different venues catering to smaller groups. The most common training venue for such dispersed training is a Panchayat bhavan and school buildings. When these are not available, the training camp may have to be fitted into an available PHC or CHC. Very often a marriage hall or private building with a larger room can also be secured for the venue. The point is that a wide variety of venues are available, if one made a careful search for it and it was worth the effort of adjusting to sub-optimal venues for the sake of keeping the venue as close to the trainees' homes as possible.

c. **Residential Nature of Training**: In a number of programmes, there has been an effort to keep as much of the training residential as possible. Where it is known that women would find it difficult to stay, such a request may be made. Arranging for a place with suitable accommodation and food is usually a challenge.

d. **Trainers and Resource Persons**: A block that has approximately 100 ASHAs would need about 5 trainers. These five trainers would have to conduct three training camps. A more likely number is about 200-300 ASHAs per block with about 10-15 trainers. Here there would be three groups of trainers with 5 trainers per group with each group conducting three training camps each. In the Mitanin programme a block had 400 Mitanins and about 20 trainers. These 20 were grouped into four groups of five each and along with one district training team member would conduct the training. Depending on the number of training groups constituted the training camps must occur in parallel so that within a month all the ASHAs of a block could be trained. If done sequentially it just takes too long- from three to six months and the trainers would get fatigued and the training would lose quality. This way each trainer has at best to provide the same training thrice- to three groups. This is an important consideration. Also a district training team member who was directly trained by the state training team could be present in all the training camps.

e. **Training Materials**: The most important training material are the training books. To supplement these, other training material like flip charts, posters, cards, audio-visuals may also be used.

Case Study: Training Materials in the Mitanin Programme

There are three levels of books, that were used for supporting training.

A. **Pictorial Books:** Two books were largely pictorial with only key messages highlighted. One of these was a summary of 5 modules. These were meant to give emphasis of main messages for all Mitanins. This was also the only book given to non-literate Mitanins or those with very low levels of literacy.

B. **Reading material for Training Camps:** The other 5 books were to be used by all Mitanins and trainers. They served as excellent trainer support material and it was insisted that the entire material be read out in each training camp and discussed. Most Mitanins who were fluently literate found the books useful as reference material later. The books were however too difficult to use for those with low literacy levels. In villages where literacy levels were in general high, such women would demand these books for they could ask their daughters or friends to read it out to them. In villages where the literacy level as a whole was poor, there was no such demand and they were happy with distribution of only the two pictorial modules.

C. **Trainer's Guide:** The Programme also published a trainer's guide. (A guide was also published for Mitanin selection.) This trainer's guide explained how each session was to be conducted and elaborated the whole training strategy. This book was critical for trainers and for programme organisers, though not essential for Mitanins.

Teaching Aids: Other training material, like charts or videos were always planned, but neither the funds nor the effort to make such aids available could be completed in the first three years of the programme. Only in the fourth year did work on such aids begin.

Discussion: What is the training material planned for the ASHA programme in your district? What can be introduced as supplementary material at your district level?

f. **Camp logistics:** Training camp logistics for hosting 5-10 training camps per block 7 times in a year is an enormous task. Once the programme is fully rolled out it means a few thousand training camps to be conducted every month or over ten thousand camps in a year in a large state.

   Very good systems are needed to:
   a. arrange for a training venue and make it ready for the camp.
   b. inform the trainees in time about the schedule
   c. prepare the food.
   d. ensure that the books and materials needed for the training have reached in in time.
   e. release the funds in time.
   f. assign a person to collect the advance, incur the expenditure and present the accounts in time.

Very often children, mothers-in-law and husbands may also accompany the ASHA to the camp and being flexible but practical in adjusting to such pressures is needed.

The heart of such arrangements is to assign a training camp coordinator for training camp to undertake all logistics management and train him/her for that purpose. The training camp coordinator can be given a check list of all the things that need to be prepared for the training and a format to fill – both of which are tools by which she/he can organise the work adequately. The block coordinator can have a similar format and check list by which she/he monitors the arrangement.

Considerable care is needed with timeliness of arrangements for very often so much time goes into the preparation of food and serving it that the quality of training suffers. There are many such details of how to avoid or manage such problems, that only close monitoring and review and peer discussions would be able to solve.

The training camp coordinator is separate from the training curriculum coordinator who focuses only on the content and quality of training, as well as in arranging for trainers to attend the programme. If the same person undertakes both roles the quality of training may suffer. Sometimes so much attention goes into cooking the food and serving it, that most of the effort and time of the camp goes into that. Separating the camp logistics coordinator from the curriculum coordinator is a must.

Each training camp necessarily has 3-5 trainers to conduct the training.

g. **Camp Activities:** A training camp is more than mere skill building. It is also about mutual solidarity and motivation. It is about peer support and recognition for the work put in. It is also to create a sense of pride and joy in their undertaking this work.

For this, in addition to transaction of training material, the training camp is a site for the following activities:

a. Meeting each other and sharing their experiences. This is cutting across caste and other local ties. Sometimes some encouragement is needed for them to be encouraged to eat together, to sit together, stay together etc. The skillful use of games and introductory ice-breakers makes a large contribution. The working together on role plays and the interactions of group work all foster this solidarity. However the block coordinators need to be sensitive to how the barriers of caste and ethnicity act and work quietly to overcome these.
b. Singing songs, especially group songs relating to women's issues and with the spirit of change. This builds up group solidarity and motivation levels.
c. Giving space for Mitanins to provide a feedback and air their feelings and opinions not only about the programme but on any aspect of their lives or problems their village faces. This helps provide support to them for problems they are facing.
d. Reviewing the work done and planning out future work systematically improves the quality of the programme.

On the Job Training

This is as important as or even more important than the training camp.

The main problem with on the job training is that it often does not occur – because of lack of monitoring and support strategy. However without on the job training, it is not possible to help the ASHA to begin work and all the camp based training gets wasted. Also this helps to individualise training, refresh its content and convert training competencies into programme outcomes.

There are two main forms of on-the-job training:

The first is the village visit by the trainer/facilitator. Since resource constraints limit the number of trainers one can have, a trainer/facilitator would have about 20 villages to visit every month and she should try to visit each village at least twice. Though the term facilitator includes the work of on the job training there is an advantage to be gained from calling them trainers as training is the very function that gets left out. The facilitators' visits tend to become monitoring and supervision visits with no emphasis on training. Problems encountered are perceived as organisational or motivational issues, seldom as training shortcomings, although these other issues are usually reflective of training quality.

Here is a sample of the guidelines issued to a Mitanin trainer in Chhattisgarh about a village visit. During a village visit, the trainer/facilitator would do the following:

a. Meet the Mitanin and seek feedback from her on her work and the issues.
b. Ensure that the Mitanin register and diary is updated. If not, update it with her.
c. Visit at least five houses which she reports that she went to or that the family met her. In these houses the trainer should support the advice the Mitanin has given. It would also help the trainer judge whether the Mitanin's advice had been effective, and if not, what additional inputs are needed.
d. Visit about 10-20 houses that the Mitanin did not go to or went a long time back and help the Mitanin handle the problems there. This ensures that the Mitanin's coverage is complete and helps in-service training.
e. Assist the Mitanin to conduct a village women's health meeting.
f. Visit the Sarpanch and some panches and brief them on the programme and their desired linkage with the Mitanin.
g. If it is the immunisation and health day, visit the Anganwadi and ensure that adequate coordination between ANM, AWW and Mitanin is established.

Two villages can be covered in one day with all the above activities. In the beginning when the programme is still new, only one village can be done per day.

Please note that if the village visit is effective then all the Mitanin's activities are supported and the Mitanin would certainly turn out to be "effective." Thus a lot depends on the quality of the trainer's field visit.

Indicators set for measuring performance during village visits/ on the job training/support in the Home-Base Neonatal Care linked ASHA programme (note each mentor- facilitator has 10 to 20 ASHAs to mentor)

a. 85% of the newborns visited by the mentor facilitator at least once during 28 days of neonatal period and 75% of the newborns visited twice during 42 days period after birth
b. 95% of ASHAs visited by mentor facilitators at least once a month, and 80% ASHAs visited twice a month
c. Mentor-facilitator attended 85% of the fortnightly meetings.
d. The mentor facilitator prepares and submits the prescribed monthly MIS within 8 days of completion of month to his/her higher level at least in 10 out of 12 months in a year
e. At the time of random check by the higher level facilitators, at least 90% of the ASHAs visited have the monthly time table of facilitator's visit
f. The mentor facilitator meets the village health council members/leaders in the village at least once in two months

g. The pregnancy register and records (other than mother new born form) of at least 80% ASHAs bear proof of checking by the facilitator (his/her signature) once in 2 months.
h. At least 80% of completed newborn forms do not have even a single error unnoticed/ uncorrected by the mentor facilitator
i. 80% mentor facilitators score more than 70% marks in their annual evaluation
j. At least 80 % of ASHAs report satisfaction with the manner of supervision of the mentor supervisor during interaction by the team evaluating the mentor facilitators
k. At least 5 out of total 6 "On the field" bimonthly evaluation in a year of at least 80% ASHAs completed by the mentor facilitator using ASHA progress book
l. Revision training/meeting of ASHAs held at least once in 3 months for each cluster (cluster means villages under 2 mentor facilitators)
m. At least 85% ASHAs attend at least 3 of these meetings in a year and there is at least 75% attendance at each of these meetings
n. Evaluation of ASHAs is conducted at least twice in a year and at least 70% ASHAs score at least 66% marks in each of these evaluations

Cluster Meetings

This is the other major component of on-the-job training. Given below is a set of instructions issued to Mitanin trainers on cluster meetings:

A cluster meeting refers to a meeting with a group of Mitanins at a local level. The venue should be such that the Mitanins can walk to, attend, and then leave and get back home the same day or in half a day. Usually it would be about 5-10 Mitanins per cluster. It is a good idea to keep the cluster meeting on the weekly market day, but this has to be decided locally.

In the cluster meetings there is a **detailed review** done. The nature of the review is to find out what problems were encountered by the Mitanin, what advice had she given to the households in her hamlet and how effective had this been, and to help her improve the quality of her work. This cluster meeting is thus a **problem solving level training.** The cluster meeting also serves to build **mutual solidarity** among the Mitanins, and to promote joint action by this group and to increase their **motivation levels.** Motivation, we must remember, is primarily increased by improving her effectiveness and then by undertaking group activities and friendliness – not by "pep" talk and certainly not by commanding them.

> **"Not by authority" – but by showing that we care – do we motivate the Mitanin. (Ruthbe se nahin lekin pyar se).**

THE TRAINER

The trainer is a key person in this picture, Who is the trainer? How are they recruited, trained and deployed? In Chhattisgarh, a number of different approaches were tried. What finally worked was to build training around a core of full time trainers assisted by ANMs and to a lesser extent by AWWs. This is the approach that the ASHA programme has adopted.

Recruiting Trainers

a) Trainers were to be recruited from local NGOs. In areas where the Mitanin programme was contracted out to an NGO, they made the entire selection. In areas where it was being organised by the health department the Preraks who had facilitated process of Mitanin selection made the recommendation.

b) **All trainers had to be women.** There are many reasons for this.
- Women trainers were likely to understand the health education components of the RCH programmes better and had better access to women when providing on the job support.
- When all the Mitanins were unpaid women, to open up the "paid" tasks of trainers to men was clearly inequitable and unacceptable. This also gave the option to capable and more effective Mitanins to take over this function.
- The trainers had to provide leadership. If they were women, the programme took on the characteristic of being a women's movement, and this was indeed desirable.

c) **The trainer workforce was not recruited and appointed – it had to evolve**: As the programme proceeds, the training team evolves. Many of the best and more qualified Mitanins were promoted to becoming Mitanin trainers without losing their assignment as Mitanin for their hamlet. This is possible only if the trainer slot is reserved for women. Also many who become trainers do so out of a spirit of social work – especially where they are selected through Mitanins. As many trainers move on after a year, they have by then themselves found and trained Mitanins as trainers to take their place.

d) **The job of the trainer is full time, with compensation**: In an average month a trainer would have to attend a training camp for three days for her own training and impart training on 9-12 days to Mitanins. Additionally, she also has to make on the job visits on another 12 days. In a non training month at least 20 days of on the job training visits are needed. This much work cannot be done by a part time volunteer. It also cannot be done by an ANM or AWW worker unless they are relieved of their routine work. Therefore it is a full time job.

However, some problems such as vested interests in selection and in regularisation may arise if the job of the trainer is retained as a regular post. As the programme progresses, the 'permanent' trainer may become more important than the CHW.

In the Mitanin experience, the following guidelines were followed to avoid these problems:

It was made clear at recruitment and subsequently that the compensation to the trainer was a training fee at the rate of Rs. 50 per day. On the days when there was no training camp, she attended a village visit, a cluster meeting or a review meeting. Thus though she got about Rs. 1000 per month - this was the maximum amount fixed for a month; this was only while the training lasted. Of course even when there was no training camps, on the job training with specific outcomes was always planned and on going – so that there was never to be a break in the programme. This amount could be given to the NGO as a package or it could be paid out to individual trainers. Though payment is made monthly, the daily compensatory character of the payment, where it is seen as a per-day fee, is maintained by the design of the pay slip. In the pay slip the number of days of training work done is recorded.

In the ASHA programme the provision per facilitator is Rs. 100 per day for about 20 days per month.

e) **ANM trainers**

Though ANMs cannot play the role of full time trainers there are many other roles in a CHW programme that they are needed for. Also they need to be involved as trainers. Therefore in the Mitanin Programme in addition to the full time trainers five ANMs per block are also trained to act as trainers. These are hand-picked motivated ANMs who help in the training process as they can reply to questions better and have better clinical skills. It adds to the quality of the 3 to 5-person training teams to have one ANM as the training team member. The ANM attends the training sessions and while giving training is relieved from her work to attend one or two days of each training camp.

Getting Trainers Trained

Training of trainers is crucial. In Chhattisgarh, the State Health Resource Center (SHRC) a specially created civil society partnership institution was entrusted with all the training of trainers so as to ensure quality outcomes. The trainings were conducted by the district training team with attendance of one person from the state training team.

Most states are moving towards setting up a full time state level monitoring and training team as there is work for such a team for 300 days in a year. The institutional structures for this need to evolve.

The district training team is made up of 10-15 persons or about three persons per block. In the Mitanin programme the guidelines was to make this a partnership with two of them from the non governmental sector – employed specifically for the programme at a compensation amount of Rs. 100 per day and a third from the government. The district training team was made synonymous with block coordinators, so that when they were not receiving or giving training they were coordinating work in the block allotted to them. The two of those from the NGO are necessarily full time and at least one of them should be a woman. The third from the government and usually an ANM or MPW or supervisor or most often the BEE who is specially interested in this work. This person may or may not be full time though the effort is to release him of all other functions.

If we have one person from the health department and one from the ICDS – both placed full time on secondment, exclusively for this work, in each block, it would be ideal.

All training of trainer camps are residential and usually last one or more days then the training of the CHW camps. Most sessions are covered in exactly the same manner in which they are expected to conduct the programme. Plus on the extra day they are trained as trainers and the trainers guidelines are discussed.

g. Supporting Trainers and upgrading their skills.

Trainers require considerable support. The main form of support is the twice-a-month review meeting held at the block headquarters. It is important to ensure the quality of this meeting and using it not only for programme review and action planning, but also as an occasion for in-depth retraining and skill building.

Trainers require also that the block coordinators and the state training team members spend a lot of time with them individually helping them cope with problems, organisational, skill–related or even personal. It is only a sense of affection and dedication that is inspired in them by the district and state leadership that can make them perform. And if the trainer has to inspire the ASHA to work voluntarily they must themselves have the spirit of dedication and community service.

TRANSMISSION LOSS: A KEY ISSUE IN CASCADE TRAINING

One of the key problems of large scale cascade training is transmission loss. The state training team trains a district training team. District training team trains a block level trainers. And block level trainers train the ASHAs. And ASHAs conduct village level training which is a sort of training for village women. As information flows down this cascade much of it is lost and worse distorted. We must remember that trainers have also lot of perceptions of their own and they would interject this into their messages. This could be useful, but often it could be wrong messages.

Quality of training is essential for outcomes, but very often the quality of training is lost in a cascade where most trainers have no experience in health care and have never been trainers before. How does one address this problem of transmission loss? There are three key strategies for addressing this:

a) Quality of Key Resource Persons or the State Training Team
b) Use of Training Material
c) Use of Training Evaluation

a) Quality of Key Resource Persons

One assumes that training loss is more at the bottom of the cascade. This is not so. Time and again we have realised that most of the loss occurs in the first step between the state training team and the district training team and loss **decreases** as we proceed down the cascade. The reasons for poor quality of key resource persons are as follows:

a. Being part of the state training team becomes a matter of status. Senior people are chosen. They usually are not the ideal trainers because they do not have the time to act as full time trainers and may just not be available for further training. So those who actually deliver the first level of training have not been trained.
b. Senior health department doctors tend to assume that since they know clinical medicine and public health, they do not need to actually follow the training guide or listen during their own training. They find it difficult to learn both content and methodology of training. Their talk during the training camp may be impressive but then when the trainers try to talk like that to the ASHAs it does not work out at all. Their talk to the CHW is also impressive but not necessarily useful to her and at any rate the senior officer or even the junior medical officer can meet with too few trainees.
c. The senior officers as trainers may not be available for visiting the training camps where district teams are training the blocks and have no feed back from the field – so they fail to be useful for improving quality of training.

Hence it is best to select a team of motivated but more junior persons with experience, either from the department itself or from NGOs or by direct recruitment. They can be placed full time in a state level programme management unit like the SHRC from where they would not only act as trainers, but also monitor the programme, and provide field level support – on the job training – to the full time district and block training teams. Considering that more than 6000 to 10000 training camps are held in a year and lakhs of ASHAs are to be trained, a full time force of 30 trainers at the state level – a ratio of 1 state training member to 2000 ASHA is not asking too much. Each state training team member thus supervises training in one district and conducts training for all trainers in that district along with the district training team. In large districts of about 8-12 blocks there could be two state training team members positioned. They are essential to ensure training quality.

> **Considering that more than 6000 to 10000 training camps are held in a year and lakhs of ASHAs are to be trained, a full time force of 30 trainers at the state level – a ratio of 1 state training member to 2000 ASHA is not asking too much.**

Once such a force is mobilised, it can be grilled through intensive training programmes to act as trainers and programme support and to provide motivated leadership for the programme.

Outsourcing to training organisations is an option – but that is just a question of deciding where the training team is located. And that would still means that a full time team is needed in the state level for monitoring and programme support. It would be excellent to have a separate team for training and another for monitoring with both being adequately trained – but this is asking for 60 full time persons in each state and it is unlikely that such funds are available or needed. At any rate in most states there is no organisation to whom the whole training could be outsourced and an SHRC may have to be created for this purpose as it was done in Chhattisgarh.

b) Use of Training Material

The other key strategy is the systematic use of training material. In such large training programmes, an insistence that the books should be transacted out line by line in small groups in addition to other modes of transaction is essential to ensure minimum communication of information. The training modules are written keeping this in mind. By this one ensures that the correct messages reach the trainees and transmission loss is minimised. This also ensures that small groups could be constructed based on pace of learning and literacy levels and more time could be spent with those who could not read by themselves. This is the key strategy to address low literacy levels. Pictorials substitute but cannot replace the number of messages that need to be heard, if not read, for adequacy. By making them repeat the messages as answers to review questions the transmission of the key messages is guaranteed. We again emphasise that "transacting training material" is in addition to other methods of transaction - it is not the only method, but it is mandatory.

c) Use of training evaluation

In built training evaluation is a key step. Training evaluation establishes that competencies sought to be built up have indeed been built up.

The evaluation may be based on a simple question and answer format, and not multiple choice questions with near-correct options which new learners find very confusing. The questions are known to trainers

before the training programme begins and cover all key messages. Evaluation is seen as a process of evaluating trainers and not trainees. It is made more non threatening by having evaluation with the same questions in the beginning also – especially when we are repeating the same book in the next round. The questions are all published together so that they could be used for on the job training also.

> **Training evaluation establishes that competencies sought to be built up have indeed been built up.**

MONITORING TRAINING

In small scale programmes a capable and dedicated leader is available to personally supervise the training. But in a large impersonal system (where sometimes, if one is not attentive, a training may be reported as completed and accounts submitted without even anyone attending). How does one ensure that something so difficult as training quality is ensured?

There were two parallel systems of monitoring. Each training programme is to be followed by filing a report that the training camp coordinator gave along with the accounts to the block medical officer or district resource person who in turn submits this to the district nodal officer for the programme who gave it to the state coordination team.

Independent of this an individual designated as a state coordination representative could attend the camp on at least one day and fill up the same format and through the state training team member transmit it directly to the state coordination team. The two reports were compared at the state level.

Further, each CHW/ASHA training camp (which is conducted by block level trainers) is to be attended by a district training team member and each training of trainers (which is conducted by the district training team) is to be attended by a state training team member. The format for reporting on a training camp needs to be developed as a simple one page format.

In the Mitanin programme since assessment of training quality was so difficult, only four questions relating to quality/processes was asked in this format:

a. Was the field visit/practicals conducted?
b. Was training evaluation done?
c. Was the training materials transacted?
d. Was there singing of songs and other mutual solidarity activities?

Though these were not enough, there was not a lot more that could be done given the logistical problems.

FAQS

Q.1. All this seems so complex. Why not leave the training to ANMs or to AWWs. If necessary train them first?

A.1. This was tried in a number of blocks in Chhattisgarh and for the first year of the campaign this was the preferred strategy. The following approaches were tried and these problems were encountered:

a. ANMs had busy schedules and their numbers were barely adequate to staff all Sub-centres. It was alright to send them for one training session or even several rounds of training but after that most district officers and block officers just could not spare them- and ANMs could not cope with their work in addition to this. In one round of 3 day training- if five ANMs are spared per block- each ANM has to give approximately 15 days of training. The Mitanin programme later restricted ANMs to the fifth training round and called them in as resource persons for one or two sessions in the rest.

b. Another option used in a few blocks was to make all the ANMs trainers of their respective areas and Mitanins. Each ANM would thus have about 10 to 15 Mitanins to train and supervise. This however had to assume that we do not need to train all ANMs intensively to act as trainers, that their current skills are adequate and that they can be removed for so many days from their current functions- all of which were proved as wrong assumptions. Here and there some active ANMs did achieve the goals – but by far the result was a very poor quality of training and even poorer motivation. Without training and sensitisation, ANMs could be rude and talk down to Mitanins, given the existing culture. The programmes in such places literally collapsed. In some places motivated officers overcame these problems by handpicking some ANMs to play the role of trainers and keeping the other trainers with the full time structure. But as the programme went into the second year, it became clear that the constant village monitoring and support visit which full time trainers could make was impossible for the ANM-trainer and without this the programme did poorly.

c. Anganwadi workers on deputation as full time trainers worked. But relieving AWW workers as such was possible to only a limited degree and in a few blocks. For the rest the experience with their use as trainers was similar to that of ANMs, only it was even worse outcomes in each aspect.

d. Doctors in public service as a rule made for poor trainers- and those who were excellent trainers were usually busy with a number of other training programmes of national disease control programmes or RCH programmes. PHC doctors were often new appointees, themselves not oriented to rural realities or with very poor job satisfaction levels, with a large cultural gap between them and the population they served. As a rule they had little empathy with the Mitanins. This could have been solved by training them well – but they were just not available for such training.

Q.2. These trainers selected such have neither clinical experience nor public health knowledge nor training skills. Why not hire trainers- may be unemployed ANMs or nurses or private doctors through an NGO to which training is outsourced?

A.2. This was not possible in the Chhattisgarh context because there were no qualified ANMs and staff nurses even for appointment in regular posts- leave alone contractual appointment as trainers. In effect all NGOs to whom programme was contracted out had also to get persons with some experience of social work and willingness to take this task and train them to play the role of trainers. However there are theoretical objections to this , and where such human resource is available they may be used , provided they are also available and affordable for providing on the job support.

Mitanin Training Curriculum

TRAINING COMPETENCIES

A training differs from other group activities like meetings, seminars, workshops etc in that it builds specific competencies in the trainee. We need to identify these competencies in terms of knowledge and skills.

Given below is the example of training competencies as devised for the Mitanin Programme.
Discuss this. Are there sections which are not needed? Are there important topics that are left out? In ASHA training programme a draft syllabus is in place in the form of four training modules? How would you express the content of these books in the form of competencies.

1. Knowledge:

Round 1

1
- Learn the definition of health
- Learn the major determinants of good health and ill health
- Learn that the perception of health as "doctors-drugs- diseases" is wrong

2
- Learn the answers for the following questions:
- Why persons often do not seek health care in time?
- Why persons often don't listen to good health advice?
- Why persons demand injections and drugs?
- How the system tries to blame the victim for his disease?
- How superstitious practices relate to health seeking behaviour

3
- Understand the objectives of the Mitanin Programme
- Understand the main activities through which these objectives would be attained.

4	• Understand that health services are entitlements or rights
	• Learn about the main local public health institutions and the services they are built to provide
5	• Understanding why child malnutrition is made a focus of our campaign
	• Understanding the multidimensional causes of child malnutrition
	• *Know the six main messages on child nutrition (exclusive prompt breast feeding; supplementary feeding from six months, five or six feeds per day, fats and oils, greens and reds, feeding during and after illness)*
	• *Learn the essential elements of new born care.*
	• Know the common illness that cause and contribute to malnutrition.
	• Know the family contexts of malnutrition- age of mother, health of mother, time available from mother for child care, space between children, support available from other members and poverty.
	• Know which health services the child should receive from anganwadi and from ANM
	• Know the common wasteful expenditures that such families incur on nutrition management and the cheap and appropriate foods available locally that could have been used.
	• Understand why children need to be weighed and what grades of malnutrition means
6	• Know the causes of diarrhoea
	• *Know how to prevent recurrent diarrhoea in children- hand washing; protecting food from flies; safe water;*
	• *Knowing how to manage diarrhoea at the village level - making and giving oral dehydration ; recognising dehydration, knowing when to refer. Importance of prompt management and where needed timely referral as key to preventing deaths.*
7	• Understanding the Management of ordinary coughs and colds
	• Preventing Pneumonia
	• Early recognition and referral and first contact care in Pneumonia.
	• Importance of prompt management and early referral for preventing deaths
8	• New born care: Need for prompt initation of breast feeding, for exclusive breastfeeding in first six months, for keeping baby warm, for weighing neonates and referring the low birth weight child, for feeding the mother, for assisting in some common problems and for prompt referral
9	• Immunisation – how and why
10	• Understand relationship of patriarchy with ill-health – especially the ill-health of women§ Brief introduction to the elements of ill-health thin women at will be introduced later in the programme.
11	• Having other doubts about the programme cleared

Round 2

1 Learn objectives of maintaining a local register - (identify families at risk to prioritise for counselling/ referral, ensure that all families have got desired services, tool of local planning later)
2 Revision of key messages

Round 3

1 Learn relationship between ill-health and patriarchy
Learn relationship between women's health and women's rights
2 Learn some major health issues in adolescence- *nutrition; anaemia, knowledge of menstruation and managing it,* feeling of adequacy about bodily functions, control over ones one self
3 Learn major causes of maternal mortality and morbidity.
Know why and how to promote institutional delivery and skilled assistance at birth
Know what are the elements of good antenatal care and how to support this.
Know dangers signs of pregnancy
Know about public health services for pregnancy and child birth.
4 *Know the elements of what constitutes good, desirable and harmful practices at child birth*
Immediate post partum care for mother and child
5 Violence and women
6 Reproductive tract infections

Round 4 (any two or three of the following four components)

A
1 Know how malaria is caused and how it spreads
2 Understand the need for early and correct treatment and making a blood smear
3 Know how to administer chloroquine tablets and maintain depot
4 Know the use of individual prophylactics- mosquito nets, long sleeved clothes, oils and creams, repellents
5 Know all elements of vector control
6 *Know to build all the above elements into a local village level plan.*

B
1 Know how tuberculosis is caused and how it spreads
2 Know the need for early and complete treatment.
3 Know to detect cases likely to be tuberculosis on basis of symptoms
4 *Know how a diagnosis is established*

5 *Learn how to monitor treatment*
6 *Learn how to construct a village level initiative (with health sector support) to ensure complete case detection*
7 Learn how to construct village level systems to ensure complete compliance
8 Learn all the common causes of cough and how to manage them at symptomatic level and when to refer them

C

1 Learn common skin diseases and how to manage them
2 *Know to identify leprosy*
3 Know what is leprosy, how it spreads and what are its manifestations
4 Learn how to construct a village level initiative (with health sector support) to ensure complete case detection
5 Learn to monitor treatment and how to build village level systems to do so.

D

1 Know when to suspect an early waterborne disease outbreak (or any other diseases)
2 Know whom to notify and how
3 Know how to suspect source of outbreak
4 Know how to disinfected a suspected source
5 Know how to notify families at risk
6 Know to promote individual and family level measures to avoid getting affected
7 Know first contact management of diarrhoea, dysentery, jaundice

Round 5 and 6 *(4 + 2 days)*

1 Understand how disease is caused
2 Understand how drugs work and precautions on its use
3 Understand how body parts are placed
4 *Learn symptomatic care for eight common symptoms- pain, fever, cough, diarrhoea, constipation worms, itch, and anaemia and when to refer*
5 Learn the management of acute severe malnutrition
6 Learn to manage simple wounds
7 Learn the use of herbal and home remedies in colds, simple coughs, small wounds and some other common symptoms
8 Learn first aid in poisonous snake bites and stings and in major injuries, in fits and in loss of consciousness
9 Learn how to transport an unconscious or very sick person.

SKILLS

These can be taught both in camp and during in-service training between the corresponding rounds of training camps.

Round 1 and 2

- Skills of establishing rapport with a family
- Learning Dos and Don'ts of how to approach and address a family on this topic at their doorstep
- Learning how to counsel a family with newborn child on breast-feeding
- Learning to counsel a family with a six month to one year old normal child on nutrition- the six key messages;
- Learning to analyse and understand the causes of malnutrition in a specific child between six months and five years and counsel accordingly
- Learning how to construct local enquiries on availability of health services and how to increase public awareness and utilisation of these services.
- Conducting a village level meeting of women; of children, of all
- Maintaining a basic health and health services register
- Weighing a child and reading a weight chart to find grade of malnutrition.
- Conveying the level of malnutrition (as seen in weighing) to the mother.
- Looking for anaemia
- Identifying severe malnutrition that needs referral.
- Making an ORS solution
- Identifying dehydration and severe dehydration
- Measuring respiratory rate(difficult)
- Recognising signs of pneumonia- as different from symptoms(difficult)
- Recognising a sick neonate who needs to be referred to an appropriate center and those who can be managed at home.
- Ability to support exclusive breastfeeding by mothers.
- Ability to train people in essential new born care and be able to initiate treatment while awaiting referral.

Round 3

- Learn to look for anaemia.
- Interpreting an anaemia blood test report to know whether it is mild , moderate or severe.
- Identifying high risk cases for recommending institutional child birth.
- Making a clean sanitary napkin at low cost.

Round 4 and 5

- Look for spleen.
- Estimating fever- manually
- Make a blood smear for malarial examination.
- Knowing how to bring fever down by tepid sponging.
- Learning to look for jaundice
- Know how to make a mosquito repellent oil.
- Identify a mosquito larva
- Know to identify and map places of mosquito breeding locally
- Be able to draw up a local plan involving all elements.
- Identify the difference between saliva and sputum.
- Identifying a person with high likelihood for tuberculosis.
- Identify the lesions of leprosy
- Know how to test for loss or decrease of sensations in a skin patch
- Know how to test for thickening of nerves.
- Know how to disinfect water in a pot with chlorine tablets or stock of bleaching powderKnow how to use bleaching powder to disinfect a well or water storage device

Round 6 and 7

- Know how to decide on appropriate diagnosis in an individual case
- Know to identify all drugs in her kit
- Know to use the drugs appropriately

CONSTRUCTING A TRAINERS GUIDE

The trainers guide should have the following:

- A brief introduction to the programme.
- How to answer common questions about the ASHA programme.
- A session by session training schedule for each round of training, also specifying what materials are needed to be kept ready for each session.
- The methodology used for each session.
- A general introduction to different training methodologies- group discussions, role plays, use of games, lectures, field visits, etc.
- Details of training strategy and training syllabus.

- Training evaluation methodology and tools for the same.
- Training camp reporting formats.
- Guidelines for on the job training.

Preparing such a guide is a lot of work and cannot be done before the training material is ready. But then it is an essential tool of a successful programme – when the programme has been scaled up to a state level.

Note : Critical Assessment of the Outcomes of Mitanin training is available on the website www.shsrc.org or at request from our postal address. Evaluation formats are also available.

Review Questions

1. What are ways to prevent 'transmission loss' in a training cascade?
2. What is meant by the modular approach to training?
3. Why is on-the-job training mandatory in the ASHA programme? Who provides it and how?
4. Trainers in a large scale CHW programme could be some of the existing staff allotted this role – or it could be creation of a distinct teams of trainers? What are the pros and cons of these two options?
5. What is training curriculum as distinct from training strategy? What are the considerations that go into drafting training strategy?

Application Questions

1. What is the list of competencies that is planned to be built up in an ASHA. Looking at the ASHA reading material could you make up such a list.
2. If we are planning for a reduction in child mortality and in neonatal mortality with the contributions of the ASHA programme, what are the minimum competencies that ASHA must have.

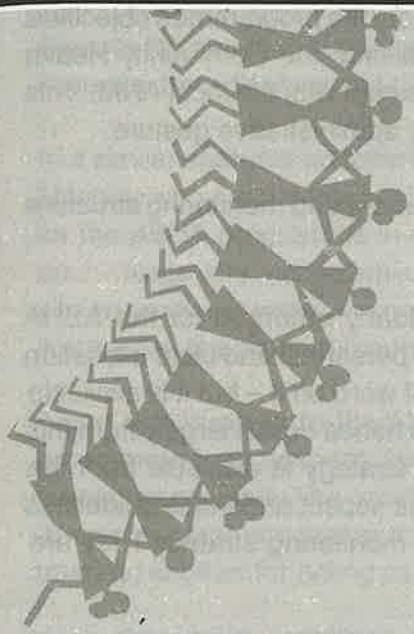
Project Exercise

1. Write a report on the ASHA trainers. Who are the trainers of ASHA in your district? How have they been selected? How have they been trained? What are their motivation levels? If there is a NGO run CHW programme nearby visit them and contrast these two trainers to understand the issues.
2. Construct a training plan for a year for one block for training ASHAs based on the training curriculum. (See also Book 5 for this task)

NOTES

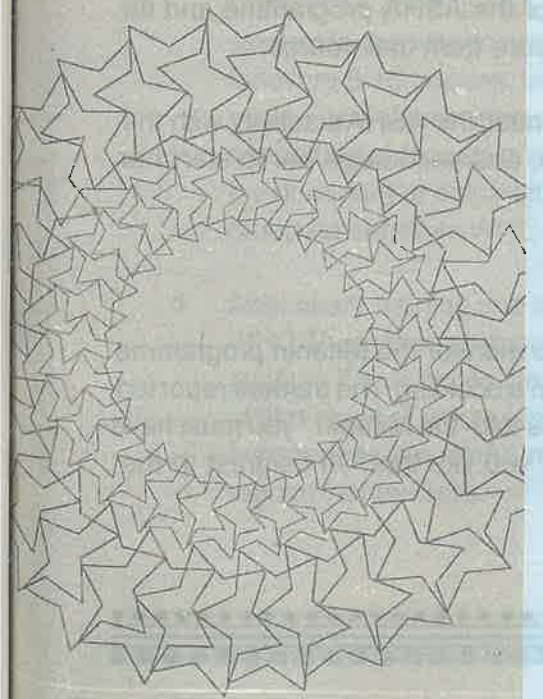
Lesson FIVE

Supporting the ASHA: Management and Monitoring



In this lesson we shall discuss:

- Nature of monitoring and support that the ASHA needs.
- Different possible support structures for the ASHA.
- Programme monitoring strategy and its indicators.
- Management structure and its roles and responsibilities.



INTRODUCTION

Monitoring and managing a programme of training and supporting 4 lakh ASHAs takes a lot of work. A romantic portrayal of a community health worker or a lack of seriousness about the programme's objectives leads to imagining the programme as one in which after some initial training, the Community Health Worker will continue to work in perpetuity without any support or contact except with the local ANM. This is typical of programmes where the CHW programme is only a political or administrative gesture.

The ASHA Programme needs to invest in building up an effective management and monitoring structure so as to realise the goals of the National Rural Health Mission.

In most states a management and monitoring structure has not yet clearly emerged for the ASHA programme. But undoubtedly a clear management strategy with adequate personnel and clear allocation of roles is a must. The experience of the Mitanin programme is not the last word on it – but it is available as a reference point against which further planning can be done. We have hence drawn largely from this for the lesson below. A critical assessment of the Mitanin management strategy is available from the PHRN and SHRC website. The NRHM has also released guidelines on this aspect and these guidelines are the central reference point for planning the state management and monitoring strategy. They are available on the NRHM website.

MONITORING OR SUPPORT?

The ASHA is not monitored by the programme management for making her accountable. The notion of accountability is very different for a volunteer, especially one chosen by the community to act on its behalf. The ASHA is not accountable to the health department. She is accountable to the community that chooses her. However in real terms the community's understanding of the ASHA programme and its own perceptions may be too weak to cause much accountability pressure from that source.

The aim of the programme management therefore becomes not to 'monitor' the ASHA's activity with the hierarchical connotation that the word 'monitor' has, but to support her, and encourage her to start her work and maintain it.

Case Study

A "programme supervisor" reported that on a field visit he had gone to monitor the Mitanin programme and had "caught Mitanins who were not working", and he had given them a scolding. The trainers reported later that this merely stopped her working altogether and the neighbors told the Mitanin " you must have been getting some wage- otherwise how would he dare behave with you like that." In contrast to the

above example the trainer reported that if she finds a Mitanin not working – then she undertakes to do those tasks herself – taking the Mitanin along – and in the process trains and motivates her to start up on her functions. Her example and her inspiration is what make the Mitanin work.

Discuss the notion of supervision in the above examples? Is this applicable only to the ASHA programme? If we pay the ASHA, would that make a difference to our approach to supervision?

In a similar example an "efficient" District Collector ordered the district health officials to "remove" all the Mitanins who are not working!!!! In contrast a sensitive District Collector who provided effective leadership for the ASHA programme in one district did so by the simple expedient of asking to meet the ASHA in each village she visited while on tour, seating the ASHA next to herself and then asking her what the village problems were. Not only did it make that particular ASHA more functional, but the social prestige it accorded the programme made it more functional in that entire group of villages.

Along with support to the Mitanins, monitoring of outcomes is essential. This is an essential tool of programme improvement. This also helps identify weak areas in the programme and take corrective measures promptly. The provision of support and monitoring of the programme is inseparable from the issue of programme management structure. Clearly no programme can have one set of staff for acting as trainers, another for acting as programme managers and a third for acting as programme monitoring.

WHO PROVIDES SUPPORT TO THE ASHA?

Support within the village :

- **Women's Health Committees:** This support comes largely from the hamlet level Womens Health Committee (WHC). This Committee is formed by the Mitanin, soon after she is selected. All the women in the village are encouraged to join. Ordinarily, the WHC comprises one representative for every 5-10 houses. In small hamlets, the aim is one per house. About 7-15 members makes a good-sized Committee, though this number is not fixed. Often no separate women's health committee is formed and the self help group used to play the WHC role. In many blocks this was the dominant or only pattern as the design had insisted that where there was a functional self-help group no separate WHC need be formed. The WHC supports the ASHA in the following manner.

- After every training she attends, the ASHA must share the information she has procured with the WHC. Thereafter, all designated ASHA programme tasks should be supplemented with Committee support. For example, her house-to-house visits can be carried out with the corresponding woman of that block of houses in tow. In a sense the ASHA should be seen as the convenor of the WHC (which does the work), rather than a solitary worker. The only individual action required of her is regular house visits.

- **Panchayat**: Support from the Panchayat and its health committee is also critical. The ASHAs and members from the WHC or the self help groups should be part of the Panchayat health committees or at least invited for its meetings. In many Panchayats, interest may be lacking even after months of work and special mobilisational measures would be needed to get them to understand and support the programmes. To maintain their interest, Block-level meetings of Panchayat leaders attended by the collector, with specific requests, should be periodically organised. Specific requests/ occasions for holding meetings of Sarpanchs could include:
  i. Meeting for ensuring coordination of Anganwadi, ANM and ASHA
  ii. Local level planning for malaria control
  iii. Campaign months against anti-TB and leprosy campaigns
  iv. Panchayat/ Village health planning drive
  v. Special meeting of Sarpanch's just after Panchayat elections are completed and new elected representatives take charge
  vi. Other specific campaigns

- **Other ASHAs:** Regular meetings and continuous interaction with other ASHAs is very useful. These meetings can be held at the Panchayat or cluster levels. The ASHAs should understand that they are an organised force - a people's movement for change.

SUPPORT FROM OUTSIDE THE VILLAGE :

i. Trainers/Prashikshaks: These provide the most important support. They visit the ASHAs regularly – at least twice every month. During these visits they help them with house-visits, meetings, and train them as needed, inspiring them to be improve their work and understanding of issues. Of all the different forms of support, this is the most important in deciding a positive programme outcome.

ii. ANMs/Anganwadis/MPWs: These form the other major support system for the Mitanins. They meet them regularly to coordinate work with them. In this process though, great care must be taken to maintain a democratic relationship which does not become a top-down relationship. Whenever the help of ASHAs is sought, for example in pulse polio, there must be a meeting where the programme is explained to them and their help is requested . The ASHAs must also be convinced that the ANMs are not seeking to pass off their responsibility but seeking their cooperation to be more effective in their work.

iii. Medical Officers: The medical officers help by providing referral services, making occasional visits to the village (at the request of the ASHA), and by encouraging them in their work. Programmes where there is some fee provided (for example, in tuberculosis drugs provision) may also be allotted to ASHAs. Only if they are unwilling should others be drawn for these services.

iv. **District Administration:** The district administration and other government employees help them through encouragement, ensuring that the ASHAs are always consulted when a village level programme occurs.

MONITORING AND SUPERVISION: SOME METHODS AND THOUGHTS

1. Strategies for Monitoring

- **Village visit and the ASHA's cluster meeting:** These are where the trainer and the ANM or Anganwadi worker gets to know what the ASHA is doing, what the problems are and provide her support to enable her functioning. The **venue** of the cluster meeting and the clustering of ASHA (how many ASHAs form a cluster) is decided locally based on convenience. Frequency of the meeting is mostly twice a month– though in many places in practice it happens only once a month.

- **Trainers' Meet:** At the block level the trainers meet twice a month in a review meeting where the block coordinators gets to know what are the developments in the area, and what are the problems ASHA and trainers are facing and provides them support for the same. The trainers can be called facilitators- but the programme felt that since so often the training element gets downplayed – we should call them trainers. The block coordinator – especially the government block coordinator – could cross-check this data by attending the monthly block level ANM meeting and the AWW meeting. A state level support agency (under NRHM this could be the State Health Society) would also need to depute a field coordinator to attend at least one of the two trainers meeting held every month in every district, so as to ensure that there is adequate understanding of the spirit of the campaign percolating to all levels.

- **District Training Team Meeting:** At the district level the meeting of the block coordinators which is the same as saying the meeting of the District Training Team is where the District Nodal Officer and the state support organisations' field coordinator gets to know the problems that the trainers and the block coordinators face and where the outcomes in various villages is coordinated. The Nodal Officer could also cross-check this data with ANMs or AWWs by attending their supervisors' monthly meeting.

- **State Nodal Officers' Meetings:** Once every three months the District Nodal Officers are called to the state capital for a strategy meeting. The Secretary, Health and the Director Health Services – who is the head of the ASHA programme always attend.

- **State Training Team Meeting:** This is synonymous with the meeting of the state training team or equivalent state programme management unit. This is the intellectual and motivational driving force of the entire programme. The state trainers we noted are also the state level monitoring and

programme support team and there are two trainers per district (one for a small district). Since they have multiple functions they are known as the state ASHA team's field coordinators (at about one per 5 blocks - or 30 for the state as a whole). The meeting is held monthly at the state office or in a separate retreat, where they are debriefed, reviewed, accounts settled, told about the coming months' plans and retrained. Sometime, this meeting is held for small groups of field coordinators for achieving intensity of review.

2. Formats have been developed for every level of reporting at each of the above levels

Formats change with the rolling out of the programme. The golden rule with formats is – keep them simple and keep the number of forms limited. Never more than three forms for the information to flow from the field to the center and seldom more than three or four active columns per form. Do not ask for too much information and from too many people.

3. Variation Across States

We note that state and district level management structures would vary across the states. What is given above is the desirable, evidence based minimum functions that are needed. This note above is indicative of how many persons must be delegated to this work on a full time basis. It also indicates the need for a separate state level support agency which is made of dedicated professionals and committed to driving this programme forward. Some States like Chhattisgarh, Rajasthan, Jharkhand have already recognized the need for such a state level institutional support – others are moving forward to reach such an understanding at the time of this going to print.

4. Indicators for Monitoring: What is Monitored ?

a) Outcomes Monitored

It takes time to evolve the key outcome indicators to be monitored. The ASHA programme has not reached this stage. Also in different states the programme has differing emphasis. Seven health related outcome indicators are monitored in the Mitanin programme. We note that all are process outcomes. Health (Impact) outcomes need a different strategy and cannot be done for monitoring Mitanins separately from the work of other health care providers. In addition to these health related outcome indicators certain organisational processes are also monitored.

b) State Level Monthly Monitoring Report:

The Monthly Monitoring Report as available in the state office would show outcomes block-wise, every month on the following indicators: The tabulated data shows:

i. How many ASHAs – out of 400 in a block – visit the newborn within the first day?
ii. How many ASHAs visit the pregnant women in the last trimester and plan with her for safe/ institutional delivery?
iii. How many ASHAs attended the immunisation day the previous month?
iv. How many ASHAs knew the exact numbers of malnourished children and had visited their families for support/counseling?
v. How many ASHAs provide first contact curative services for more than 10 to 20 persons in the village last month?
vi. How many ASHAs are DOTS providers?
vii. How many ASHAs conducted one or two hamlet level womens health committee or equivalent meetings last month where health issues were discussed?

This only gives a broad overview of functionality and keeps the focus on outcomes. *(these are not outcomes in a strict sense but also processes but this is as near as we could get to outcome monitoring).*

This had to go along with a number of other process indicators. These were available at the state level and pertained to each block:

i. How many trainers meetings were held last month in each block?
ii. How many trainers (out of total number stated) attended the meeting.
iii. Till which month as trainers fees been placed
iv. When was last district training team meeting held? (Once per month is mandatory.)
v. What is the number of Mitanins/ASHAs trained last month? Which round of training currently going on and how many Mitanins/ASHAs have been trained?
vi. Are Mitanin/ASHAs drug kits refilling systems in place?

c) District level Monitoring Report:

All the above as given for state level. In addition to the above, we require to know:

1. How many cluster meetings were held? Of the number of Mitanins per cluster, how many attended?
2. How many hamlets did trainers have to visit? Of these how many did each visit?

d) Block level Monitoring Report:

All the above indicators as applicable to the state and district levels. In addition to the above, we require monitoring on :

- How many newborns were weighed? How many were referred and what happened to such referrals?
- How many were referred for institutional delivery? And in how many did they receive adequate facilities and services?
- Of these how many were eligible for Janini Suraksha Yojana incentives and how many actually received it?

How many Mitanins/ASHAs received their immunisation day attendance incentive?
How many Mitanins/ASHAs have their drug kits refilled? If not, what drugs are not refilled?

5. Cross-Checking of Monitoring Reports

In addition to the above during each phase of the programme other indicators useful for that month or to monitor a specific campaign were included from time to time.

FAQ: *Almost all indicators are such that they are based on the Mitanin/ASHA's or trainers reports. Since Mitanins/ASHAs are unpaid the question is often asked – what if they are not telling the truth?*

Answer: Since Mitanins/ASHAs are not paid, but volunteers they have little interest in giving false reports. Of course social prestige and a human reluctance to confess poor results could be reasons. But these are easily obvious to someone who knows and has worked with the programme.

CASE STUDIES OF INTERACTIONS IN A ASHA REVIEW MEETING

Case Study A

Suresh, Field Coordinator (FC) during a ASHA cluster meeting asks an ASHA:

Field Coordinator: *Did you go on house-visits?*
ASHA: *No.*

Field Coordinator: *Why not. You should be going. There were some newborns in your hamlet. Did you at least go to their houses?*
ASHA: *Yes I went.*

Field Coordinator: *What advice did you give? How many did you refer?*
ASHA: *Oh I ask them to breastfeed. All of them were normal weight –but I did not weigh two of them.*

Field Coordinator: *You should have weighed them too. They may have been underweight. You should increase referrals also.*

Case Study B

Archana, another field coordinator during a cluster meeting asks an ASHA.

Field Coordinator: *How many children were born in the period since my last visit?*
ASHA: *Three children were born.*

Field Coordinator: *How many of these children were you able to visit at their homes?*
ASHA: *One was in Netam's house, another in Das family and the third was my next door neighbour. I went to all their houses.*

Field Coordinator: *How are the babies? Was their birth normal? Any problems with any of them?*
ASHA: *In all 3 houses they were normal deliveries seen by the Dai. In Das and my neigbours house they started breastfeeding within the hour- though Das's house took a lot of persuasion. They also followed advice on keeping the baby warm. Their children were weighed – I got the Anganwadi worker to do it.*

Field Coordinator: *What were their weights?*
ASHA: *In Das's house the baby boy was 2 kg and in my neighbour's house the girl weighed 3 kg.*

Field Coordinator: *Very good work. And in Netam's house?*
ASHA: *Oh there I went later. Their family doesn't quite like our going and talking. And they took one day to start breastfeeding. They even refused to weigh the baby.*

Field Coordinator: *Then come, let us go together.*
ASHA: *Come to my neighbors house first, the child has been regurgitating the milk and they are worried.*

Suresh will get lied to. He can never be sure whether the report was true or false.
Archana will always know the truth.

What is the difference in the way they have approached the task of monitoring? Discuss the significance of the different dialogues in contrast to each other.

If the spirit of the monitoring person is to understand the health outcomes in specific instances and support the ASHA in providing support/services to the families in her care, then she will be effective in providing support, then monitoring will be non-threatening and the truth of the responses can be easily determined.

6. Cross -Checking

This does not mean that the need for cross-checking the reports are less. Indeed they remain – but the reasons are different:

a) We need to assess the perception of ANMs, AWWs and other field functionaries to the programme and by dialogue with them improve their perception. Not that their reports are not truthful or that the ASHA report is correct – but that the gaps in perceptions between the two can be narrowed.

b) There are problems of understanding and of quality. Often a trainer may be authoritative in monitoring and may have triggered off false reports and a district training team member or State level support organisation's field coordinator may have to identify this and take corrective action. Or a ASHA may be reporting a meeting where two or three women attend as a village women's meeting etc.

APPROACHES TO CROSS-CHECKING

Cross-checking should also be a part of provision of support and on the job training to ASHAs and trainers.

Whenever a state training team member or a district training team member attends a trainers' meeting they are required to spend one or two days more in the same block and follow up with a visit to one of the trainers' areas and attend a cluster meeting and complete a village visit. The findings of this visit need to be compared with what had been reported at the trainers meeting and that leads to a general assessment of the reliability of the trainers reports. From time to time volunteers from other blocks can be invited to do the same and this is what we called building in an element of externality into internal monitoring. It increases the quality of internal monitoring.

Similarly some of the data provided by Mitanins/ASHAs can be cross-checked with data in facilities (about referrals) and with ANMs/AWWs – about attending immunisation day, utilisation from drug kit (for curative care use), for newborn care (BCG utilisation), for counseling of malnourished children etc. Note that in such cross-checking neither sources of data should be seen as the truth. Here one should by trying to reconcile the two versions not only lead closer to the truth but also build a better understanding between the various field functionaries. This is true of reconciling reports between ANM and AWW also – which almost never match each other.

PROGRAMME MANAGEMENT STRUCTURE

1. **State Level:** At the state level, there are two structures:

   a. One is the **State Health Society** which approves the project and the budget, reviews the programme and approves the programme design. The Directorate of Health Services acts as its secretariat.

b. The State Health Society is assisted by the **State Health Resource Center**. The State Health Resource Center provides technical assistance in programme design, in training and in monitoring as well as any such assistance as the government may require to handle the programme. The Director, SHRC or a programme coordinator appointed by the Director, SHRC is the nodal officer for the ASHA programme and would coordinate programme management with the director. Though the SHRC may issue guidelines, orders however are issued only by the Director of Health Services.

2. **District Level :** At the district level also there are two structures:

a. **District RCH Society/District Health Society** shall be the coordinating body. In between meetings of the RCH society a programme management unit made of the secretary and president of the society, the district ASHA nodal officer and some members nominated by the RCH society shall make the necessary decisions. A separate district coordination committee for the programme is not mooted because the District Health Society or District RCH Society is expected to play this role- and it is better to invest in strengthening that – than in setting up a new committee. The District Health Society decides who shall be the district and block nodal officers and which NGOs it would invite to participate and at what terms.

b. **A District Resource Persons team (DRP)** (also called the **District Training Team, or DTT**) made up of **those working full time** at that level may be constituted for day to day work and functioning with the nodal officer convening it. Ideally this district team is made of motivated individuals from NGOs, from health department and government departments specifically allotted this task and working almost full time for its successful outcome. All funds for the programme in the continuation phase shall be received and accounted for by the district RCH society – for all blocks.

c. **Block Coordinators and District Resource Team are synonymous** . The district resource persons are drawn from each block. Each block provides three district resource persons- one of which has to be from the government and allotted full time, or at least most of the time for this task. Two of them are from NGOs or are trainers of the ASHA programme promoted to play this role. When in the block these three are known as Block Coordinators. It is desirable that at least two of these three are women and it is compulsory that at least one of these three are women.

3. **Block Level:** The block is the unit of planning and programme implementation.

Programme is sanctioned and funds are earmarked and released block-wise. The funds released by districts are received by the block medical officer or in some cases by a block nodal officer. Monitoring and evaluation and achievements are also denoted with block as the unit. The district and state levels however have important roles to play in training and in guiding and monitoring the programme at the block level.

4. Block Coordination Committee and BlockTeam:

At the block level, a coordination committee with the BMO (or in the event of his being ineffective, another suitable person from the health department where specifically needed) chairing it shall coordinate guide and implement the programme. The BMO is helped by the three-person team of block coordinators described above. This coordination committee shall have representatives from the health department, other government department and NGOs. If there is an NGO to whom the funds are being given the NGO shall nominate the secretary of the committee. The final decision on the composition and functioning of this committee at the block level is with the District RCH Society.

5. Block Level Institutional Mechanisms:

This determines the nature of NGO participation in the programme.

In about 50 blocks NGOs are supporting/managing the programme. Three arrangements for participation of NGOs in decision making and in financial management have emerged.

a. **Contracting-out (NGO led Model):** In the Raigarh model the entire funds for the block programme are given to an NGO which has the entire responsibility for the block.

b. **Contracting-in (Government led) model:** In the Bastar model, the funds for the programme are given as advance for each activity from the district nodal officer to three DRPs- two of whom are from an NGO chosen for each block and one of whom is a government person. Most of the funds are therefore not given to an NGO though individuals can be given advances and at times the organisation can be given funds for a specific activity – like a round of training camps. Here the resource person/NGO has been contracted in.

c. **Government led with Supportive NGO model:** In a district like Korba the BMO and government DRP manage the funds- paying the travel and training costs of the work done by a lead NGO and the trainers it has provided. Here no funds are as such given to the NGO or to any member of the NGO, though the NGO may use the programme to build itself a wide village level membership and presence. These variations and flexibilities depend on the relative strengths and confidence enjoyed by different NGOs as well as the subjective decisions of the RCH society. **The governing principle is that the funds and programme management structure is decided by the district RCH society which is 'sovereign' in this regard and SHRC only helps improve the efficiency of whatever system has been adopted.** (There are 15 pilot blocks where funds go direct from the state level to the NGOs, but after the first three years even these are being brought under the district RCH societies.)

d. **Only the Government, with selected full timer trainers:**
In many districts like Raipur, the government block officer would insist on doing the training alone and handpick some individuals, often with NGO background to provide support. In some places this was inevitable for there was really no NGO available. But in many places it was just reluctance to let anyone from outside in. Most of them regretted the decision as work increased and tight monitoring ensured that they delivered. But since their experience from other programmes had been that in some low priority programmes they could get away with inaction there was considerable resentment of this monitoring and the hard work that they had taken on. However in many blocks using this approach the programme fared very poorly.

MANAGEMENT ROLES AND RESPONSIBILITIES

A clear management strategy with adequate personnel and clear allocation of roles is a must, but it has not yet clearly emerged for the ASHA programme. The experience of the Mitanin programme is not the last word on it, but it is available as a reference point against which further planning can be done. A critical assessment of the Mitanin programme's management strategy is available from the PHRN and SHRC websites.

1. **State Health Society** - with Directorate acting as its Secretariat:

- Approves the Annual Plan and Budget for the programme.
- Receives funds from the GOI/other sources for the programme.
- Expends funds: Transfer funds to SHRC for training & material production and purchases and procurement of drugs done by directorate directly.
- Issues all orders needed for the execution of the programme - the programme is therefore conducted by it.
- Conducts review of programme with chief medical officers and with district nodal officers.
- **Signs MOU with SHRC for providing technical assistance and programme and financial management support.**

2. **State Health Resource Center (SHRC)** (Now renamed the SHSRC - State Health Systems Resource Center, in other states)

The creation and functioning of the SHRC has been critical to the success of the programme. The SHRC has used about 6% of the total funds of the ASHA programme for its functions in providing support to the ASHA programme. The cost of training of trainers is additional to this. The support functions of the SHRC include:

a. Design the programme, development of programme guidelines and its dissemination and use at all levels. This includes repeated assessment visits to the field and a number of workshops and interactions

b. Development of training material
c. Training of district training teams
d. Training of block training teams
e. Training of state training team
f. Sensitization of officers at different levels
g. Close interaction with participating NGOs and incorporating their inputs and views
h. Training of kalajatha teams and leading other aspects of social mobilisation
i. Monitoring training quality, and programme outcomes
j. Internal Evaluation of the programme
k. Advocacy to support the programme
l. Ensuring adequate financial management of the programme
m. Supporting district level Programme management
n. Creating linkage with improving public health systems work
o. Creating linkages with ICDS, water and sanitation and education work at the state level
p. Any other support that state or district health societies may need for programme management.

However the key dimension that the SHRC contributes is to capture the spirit of the programme and transmit it to the different levels. This, it is able to do because of its unique institutional character and strategy. This is discussed elsewhere.

STAFF STRUCTURE AT THE STATE LEVEL:

Programme Coordinators (Three): Two for training and monitoring, and one for material development- in the initial months. Also one plays the role of State Nodal Officer for the ASHA Programme.

Field Coordinators: One for each of 5 blocks or 2000 Mitanins/ASHAs. In total, 30 field coordinators – who also form a full time state training team.

Roles of field coordinators:

- As the state training team, to train the district teams,
- Along with district trainers, train the trainers of the Mitanins,
- Attend regularly all block level trainers meetings to monitor the programme functioning,
- Visit a sample of villages and attend sample of cluster meetings to monitor and assess programme functionality,
- Interact and support programme managers at block and district levels to ensure that funds flow, and necessary orders and follow up instructions are facilitated and that programme weaknesses are addressed; also to ensure coordination with referral support, drug kit refilling etc.,
- Function as the eyes and ears of the programme.

3. District Health Society

- Approves the annual plan and budget for the programme.
- Receives funds from the state health society and expends and accounts for the funds.
- Appoints the district nodal officer for the programme.
- Reviews the programme.
- Selects the NGO to whom it contracts out the programme in the block level- and reviews its programme.
- Issues all orders and guidelines for the programme at the district level.

District Nodal Officer

- Appointed by the District Health Society – by the district collector and CHMO in consultation,
- Convenes meeting of District Health Society and District Resource Persons Team/District Training Team,
- Collects monitoring reports from the DRPs, collates it and sends it to the state and to the district health society,
- Arranges for fund flows to the BMO, block level organisers and collects utilisation certificates from them and transmits it back to state,
- Supervises functioning of DRPs and makes changes in them where necessary following due process.

4. Block Coordinators (synonymous with District Resource Person)

- Assigned the task by BMO/District Nodal Officer in consultation with rest of block coordination committee,
- Provides training for trainers (also called block resource persons) in one block,
- Convenes meeting of trainers twice a month in his or her block to review programme and upgrade skills; this is the most central activity component of programme monitoring,
- Collects reports from trainers in their respective blocks and submits it to the district nodal officer,
- Organises logistics and funds for the training camps,
- Makes visit to sample of villages and by rotation to all cluster meetings of Mitanins for supervision and on the job training of trainers. At least 15 days per month is on this activity alone.

5. Block Resource Persons (synonymous with trainers of Mitanins)

- Assigned the role by the DRP in-charge,
- Has to visit every ASHA in her village twice per month and spend a few hours working with her – in visiting houses, in talking to the Sarpanch, and in conducting village level women's meetings; about 15 days per month go in this task of on-the-job training,

- Training the Mitanins/ASHAs in ASHA training camps,
- Conducting a cluster level review meeting of Mitanins/ASHAs twice a month. The cluster is chosen as the Panchayat or sub-center level or haat depending on the convenience for Mitanins to attend – they should not have to pay for travel!! This activity is central to programme monitoring.
- Helping the ASHA in completing her register,
- Gathering data of ASHA functionality and health issues from the cluster meetings and registers and transmitting the information to the DRP.

FINANCIAL MANAGEMENT

Managing a large flow of funds, across so many habitations and so many diverse partners and institutional arrangements was a major challenge for the Mitanin programme. Without close attention to financial systems development at the state level, this would not have been possible. To do this the SHRC had only a senior accountant, an accounting assistant and a fixed contracting-in arrangement with a chartered accountant, selected for his ability to develop procedures creatively.

At the district level one accountant was to assist the nodal officer and at the block level one accounting assistant was to assist the government DRP and the block medical officer.

The funds flow from the state health society to the district health society through the SHRC. This was decided by the governing body meeting of the State Health Society as it ensured closer monitoring and prompt collection of utilisation certificates. Given the overload on the Directorate, this role has been very useful.

The District Health Society in turn gave the funds to the BMO as an advance. After incurring the expenditure they would submit the bills and vouchers. Where it was an NGO-led programme, the fund would be given to the NGO and they would submit an audited utilisation certificate.

It was a requirement that at least 90% of the funds be expended and utilisation certificates (UCs) submitted before the next sum was released. Since the submission of UCs was the single most important reasons for delay in the programme, at every level one of the field coordinator's priority task was tracking the flow. So whenever a UC did not come from a district, the FC would be required to find out whether the bottleneck was:

- At district level – in releasing of funds to the block (usually a collector unwilling or too busy to sign the release);
- At district level, the failure to put the bills and vouchers together, and with the final cash book and ledger present it to the auditor;
- At the block level – failure to carry out the activities and expend the funds;

- A failure to put together the bills and vouchers and make a statement and submit it. Sometimes this delay was not the block's fault, but due to the district accountant's refusal to accept bills and vouchers for part expenditure demanding that full expenditures be shown. It was absurd to insist on this – but we never quite cured that problem. Except for this problem, the lack of capacity was never the problem for delay in submitting the accounts;

Once the precise place of hold up is determined, a set of pressures is applied at that point to overcome the constraint and keep the funds flowing. Delay in accounting almost always implied weak reliability and accountability, and hence very skillful pressure could often be needed as the persons causing delay would be quite immune to any pressure from legitimate programme managers.

The lack of proper flow of accounts was at many times the single biggest problem that the programme faced and one of the biggest contributors to poor performance. For instance, of the 15 blocks of Raipur district, two or three blocks were very good performers, another seven or eight were good, another three or four were poor and two were consistently negligent and terrible. The state could release the next installment to the district only if the district had presented complete accounts. The best blocks would have spent their money and due to lack of funds would face an interruption in the programme for over six months. But two blocks just never bothered and were beyond disciplining. When the funds were finally released, the best blocks had been reduced to poor performance and of course the already poor performers did not improve. Thus over time all blocks would do badly. The need was to develop a financial system where bad performers did not lead to spoiling the progress of good performers- and this took a lot of doing, for accountants would insist on the 75% UC as an absolute criteria.

Details of the budget and some lessons on proper utilisation of budgetary provision may be found on the website.

Critical Assessment: Monitoring and Support: See the website for the evaluation reports of the Mitanin Programme:

Mitanin Participatory Evaluation, March 2004
SHRC Study, December 2004
CHC Study, March 2005
Mitanin Analytic Documentation, September 2006

Note: The Home Based Neonatal Care(HBNC) Programme is going to be implemented throughout five states in synergy with ASHA programme. These states are Madhya Pradesh, Uttar Pradesh, Bihar, Rajasthan and Orissa. Perhaps this will also be extended to all other EAG states. The HBNC team led by SEARCH has worked out the details of a programme monitoring and support structure that is adequate for the ASHA programme and may be learnt from by all states. Details of this structure could be had from the PHRN or directly from SEARCH.

Review Questions

1. What is the difference between monitoring the work of ASHA and the work of other health workers who are government employees?
2. What are the organizations and people who provide support to ASHA in her work? To whom is she accountable?
3. What is the nature of programme management arrangements at the block level?
4. What is the role of a state level support organization for ASHA?
5. What are the indicators suggested for monitoring ASHAs work?

Application Questions

1. Does the creation of so much management structures bureacratise the programme? Or is it essential for maintaining the health rights and civil scciety spirit of the programme? Both views have been expressed. How would one understand this?
2. Are the principles of monitoring applicable only to the voluntary work force or are there lessons here for workforce management of even the regular paid workforce?

Project Exercises

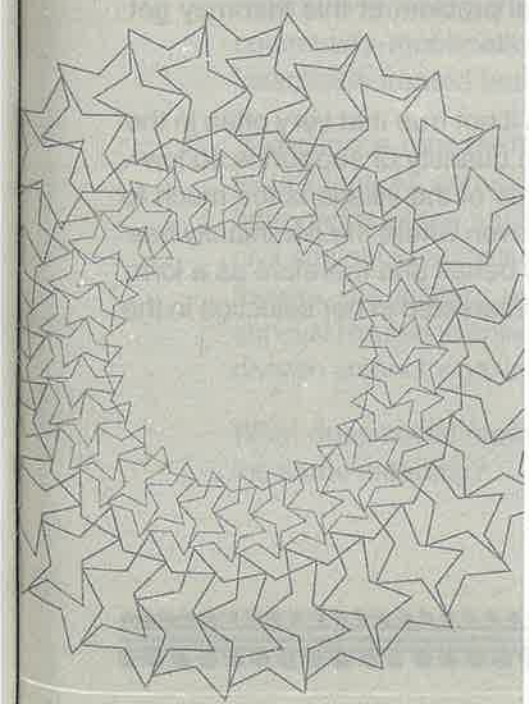
1. Draw up and budget the costs of managing and monitoring and supporting the ASHA programme in your district. Check the annexure for the details of the ASHA budget and see whether it fits in?
2. What are the indicators in use for monitoring the ASHA programme in your district? Propose indicators and means of measurement of these indicators and design formats by which this data can be collected and the persons through whom this is transmitted upwards to the district headquarters.

Lesson SIX

Community Mobilisation, Social Mobilisation..... and the Spirit of Enterprise

In this lesson we shall discuss:

- The meaning of the terms social mobilisation and community mobilisation.
- The need for community mobilisation in community participation and community health worker programmes.
- The forms of community mobilisation.
- The 'factor X': Other than selection, training, monitoring and management there is something extra needed to make for a successful programme of community participation - this is what we call the spirit of the programme.
- The limitations of community mobilisation and its relationship to the formation of institutional structures.



CASE STUDY

A programme coordinator of a leading community health worker programme guided a key Directorate official on a visit to see an ASHA programme. At the end of a three hour visit when they had returned and the programme management group had assembled to meet him, the coordinator asked the official what he thought of the programme. The official quietly murmured, almost reflectively, "The ANM has not worked. The Anganwadi Worker (AWW) and the Anganwadi sevika have not worked. The PHC and the CHC is not functioning. The supervisors have not done their job. The Panchayat has a sevika and a structure and that too has not delivered. Now you create another person – called ASHA, say that you will not even pay her and expect her to solve all by herself, all the problems that everyone else has not solved."

Discussion

Persons working in the district for creating change would recognise this comment for what it is – a knock out blow. A single devastating rhetorical question that admits of no answer and leaves the facilitator breathless. The person asking the question would indeed be surprised and amused if you even try to answer this question. But facing such knock out blows is part of change management. In the field one has to learn to cope with such questions. Let us now do a serious analysis of this statement.

This statement is devastating precisely because it is so correct. Of course the ASHA cannot solve all the problems. Nor is it quite true that the ANM and AWW have not worked. Though very often when asked on the field why we need an ASHA, an immediate and unthinking reply maybe... "because the ANM and AWW are not delivering". By exaggerating the programme coordinators positive assessment of what the ASHA can do and also exaggerating the limitations of ANM and AWW, the expectation of the ASHA vis-a-vis the existing worker is made to look ridiculous. However the central problem of this that may get missed is:

Do we expect the ASHA to do all this "all by herself?" Certainly not. But is it not true that very often in the villages especially in large scale programme where the quality and even quantity of support is so low - the ASHA does often become a person all by herself and then the inertia of the village is too much to overcome. How do we get the community to act? How do we ensure that even where the community has selected the CHW, it continues to own her actions as actions done on its behalf and therefore as a form of community participation? How do we ensure that the community gets interested in her selection in the first place?

All this needs Community Mobilisation

Consider the following statements. Would you agree with them?

- Community Mobilisation is needed to make community participation happen.
- Community Mobilisation is needed to make the community health worker (in our case the ASHA) selection becomes a community decision.
- Community Mobilisation is needed to make a community health worker (ASHA) effective.
- Without mobilising the community a community health worker cannot be effective.
- Community participation and therefore community mobilisation is not just a means to achieve goals- it is a goal in itself.

a. What is Mobilisation? What is Community Mobilisation and What is Social Mobilisation

By Community Mobilisation we mean a set of processes that energises and enthuses numbers of people, organises them and moves them to take action together and individually. This includes the creation of a facilitatory environment.

The term is used interchangeably with social mobilisation. The pattern of usage is to use community mobilisation to refer to the entire community in a localised area – village or Panchayat. When we say social mobilisation we refer to mobilisation over a much larger area, - block, district or state. Or we are implying the mobilisation of some social groups preferentially and are avoiding the connotation of a "homogeneous" community.

Study these three quotations:

1. "The malaria control programme had not been able to make much headway in the district of Palamu. Reviewing the programme it was decided to revise the strategy and to invest more in community mobilisation for source reduction in addition to spraying and other distribution of insecticide treated bednets."

2. "Experience repeatedly confirms that pushing for urgent health action on the health system is insufficient. All domestic actors should be mobilised, greatly expanding beyond the traditional boundaries of the health sector. The actors extend beyond government to include business and civil society. Imaginative engagement has included the entertainment industry, local and street theatre, the military, women's associations, sporting groups, and traditional healers. The child survival revolution spearheaded by UNICEF in the 1980s employed 'social mobilisation' to engage diverse actors for growth monitoring, oral rehydration therapy, breastfeeding, and immunisations."

   What does social mobilisation mean here? Could we use community mobilisation here and get the same meaning?

3. "Perhaps one of the grandest health efforts in the 20th century was the eradication of smallpox. How does mobilising vast cadres of workers for such campaigns strengthen or weaken health systems?"

   This statement refers to 'mobilising', but neither 'social mobilisation' nor 'community mobilisation'. Is it not enough that the department's workers are ordered to do this work? Why use the term 'mobilisation' in this context? What could it mean to say to mobilise the department staff for a particular task?

b. What are the features of mobilisation as relevant to supporting the ASHA Programme?

CASE STUDY 1

In Borda village of Shamtari Panchayat of Koriya district, the facilitator went for assisting the selection of the ASHA (Mitanin, in this case). She talked to the Panchayat chief who told her that no one was willing to undertake this task. Then she held a meeting where she announced "the government is organising a scheme called ASHA. You are required to select a volunteer who is to work voluntarily. Right now there is no provision for making a payment. She has to help the ANM and AWW in their work with the community". A number of local women loudly protested that who is going to do all this work without any payment. No one volunteered. The situation did not change even after talking to the ANM and AWW.

Left with no other option she managed to find a woman with two young children who had come to her for advice on child care. The woman seemed bright and curious and after talking to her she got interested. So the facilitator got the gramsabha and Panchayat to approve her name and forwarded it to the programme authorities at the block level."

CASE STUDY 2

In Gutla village of Rambari Panchayat in Dumka district, the facilitator went to assist in the selection of a ASHA (called Sahiyya here). She held a meeting where she explained the programme in detail. She emphasised, "this is an opportunity for the village to ensure that it gets all the services. Just expecting the government to deliver is no use, unless the community is also willing to take initiative. Also we will provide a set of drugs for use to address small local ailments". She met the Panch, and got some names from him. Met the ANM, and AWW and also got some names from them. Then asked the self help group who suggested some names. When she met many of the suggested names- many did not agree to the conditions– though some were willing to consider them. These were short listed and placed before the gramsabha which after discussion agreed on a name. This name was endorsed by Panchayat and forwarded.

CASE STUDY 3

In Bhatagaon village of Siwan district, the facilitator went to select the ASHA. The Sarpanch had already decided on a name which he said he had done with consultations of other Panches and the village heads of each hamlet. The village had heard about the programme because the district collector had discussed it in some detail. Also the village had hosted a two hour long Kalajatha programme which had extolled the role of the ASHA and given an altogether different portrayal of the role of the ASHA. A large number of women when asked said they would be interested but wanted to know what would be required of her. The facilitator then organised repeated meetings in each of the villages where she had described the programme.

"This is an effort by the community to take care of much of its own health needs. You need to select a volunteer whom we will train to help you do this. The volunteer will also ensure that every family has received the basic services that it has a right to receive. Today we know that many families especially in the weaker hamlets are getting left out and this must change. But this will change only if people in the hamlet take interest in changing this – and securing their rights."

After the meeting, the women suggested that they should have a different name for ASHA. Many women volunteered. Many of them had seen the Kalajatha programme and had heard about on the radio. There was a discussion. It was decided that among those who can read and write well, the house where the family will support and hence she can give more time is the best person to choose. When asked about the name that the Sarpanch had suggested, they kept quiet. When asked which name they would prefer, they repeated their choice. When asked what the problem with the other name was, they said she is a good choice for that part of the village, but not for us!!

In the gramsabha, the Sarpanch came and despite being told, suggested only one name - the one he had already decided upon. The facilitator mentioned that according to rules all the hamlets could suggest names and according the meetings he had held – the other names available were and he gave three names. Then he said based on the criteria that the woman should be educated, and that she could give time – he suggested that of the three, one name be considered. Most of the participants agreed to the name.

It turned out that the name the Sarpanch was suggesting was not interested and moreover was already holding one or two committee positions. Faced with this reasoning and the agreement of the majority, the Sarpanch said ..'ok let her be...' But commented later 'The facilitator put a poor woman in the ASHAs place just because she is so talkative, let us see her functioning.' But the others said'...let it be – we can go to her house anytime for taking drugs – but we cannot disturb the others household like this'.

Consider the above three examples. In each of three case studies note:

a) How many women were willing to become ASHAs? Why do you think there is such a difference?
b) What was the image of the programme that the facilitator painted?
c) What were the considerations that went into selecting the ASHA? Which of the three would you consider a choice by the community? Who spoke for the community in each case and what did the facilitator facilitate?

In the third situation social mobilisation has taken five forms:

a) Meeting in which the collector seems to have announced the programme to Sarpanches and made it important enough for the Sarpanch to initiate action.
b) Kalajatha- which conveyed the programme and its spirit.
c) Radio programmes on the ASHA (Mitanin here) Programme
d) A number of village level meetings held by the facilitator.
e) Meeting of the gramsabha.

All this together has created a facilitative environment that promoted

a) High social recognition for the programme.
b) Social acceptance for women to play this role
c) Therefore a number of volunteers from which the community could choose – in contrast to the first situation.
d) But has also brought conflict since women from weaker sections who would have remained silent were energised by the *Kalajatha* and the presentation in the meetings to bid to become ASHAs.

Also note that each of the above five activities by themselves would have been only an organisational process or a communication programme- but taken together they act as "Mobilisation".

CASE STUDY 3 (CONTD.)

A Block Medical Officer's response to Case Study 3 given above was this:

"This is good case study of selection but the facilitator was not needed. Without him they would have gone by the Sarpanch's decision and that is the true choice of the community- not the promoted selection of a poor talkative woman Why do you assume that the Sarpanch did not take the choice of the weaker section into consideration. A more educated person from his part of the village would get trained better and have better Sarpanch support and therefore be more effective – even in outreach to the weaker sections.

The facilitators presentation and the meetings amongst the weaker sections was an external intervention and external influencing of the selection process. The facilitator should have left it to the community".

Discussion

According to the officer social mobilisation that led to the Sarpanch taking interest in the selection process was good. The *Kalajatha* that led to a number of volunteers to choose from was good. But the actions- both *Kalajatha* and meetings - that energised the weaker sections and articulated their needs were wrong.

In a community there is a choice to be made on mobilisation. Some people are alert or have access to decision makers/information and act at once. But many sections, especially the poorer, less educated sections are used to their views being ignored or may want to avoid conflict and thus would not participate. They would require to be mobilised.

So though all parts of the community are mobilised some sections need more mobilisational inputs. When we say community mobilisation it seems that all parts of the community are mobilised equally. But when we say social mobilisation it seems that some social groups are the focus of mobilisation efforts and not the entire community as such.

ASHA FUNCTIONALITY AND SOCIAL MOBILISATION

CASE STUDY 1

The trainer reports that the Mitanins/ASHAs in her area are losing interest in the programme. She visits the Mitanins/ASHAs regularly and she attends the cluster meetings to review the programme. She has organised small clusters of 5 Mitanins/ASHAs each, as the meetings can be held nearer to their homes. But often Mitanins/ASHAs do not come. But still most Mitanins/ASHAs are ready to go to visit houses only with her – and even this after persuasion. There are no village meetings since few women turn up for such meetings. The trainer explains – "it is three years now, and she has been paid nothing. When she had so much problems getting the Janini Suraksha Yojana money - she got very put off with this. And they do not listen to her referrals in the CHC. I am not surprised that they have lost interest".

CASE STUDY 2

The trainer reports that the Mitanins/ASHAs are functional in her area and they are much more enthusiastic than earlier. The Mitanins/ASHAs look forward to their next meeting. Usually there are 15 to 20 Mitanins/ ASHA who attend. The meetings are held on the haat day at the PHC in the haat village. The trainer somehow arranges for tea to be served. Personally greets every Mitanin/ASHA. They start with singing

a few songs. These are popular songs that deal with women's empowerment and issues concerning vulnerable sections. There is a Mitanin clap- a coordinated clap which is half a joke, yet taken quite seriously. Each Mitanin/ASHA relates her experience and all discuss what could have been done. They have arranged for the doctor to come and meet the group and he needs some persuasion to make his appearance – but once he comes he is quite encouraging. The Mitanins/ASHAs have already had a detailed review before he comes and on the prompting of the trainer each Mitanin/ASHA presents some work she has done or asks one or other question.

They also decide that they would all be meeting in the wedding in one of the villages where they have arranged for the other Mitanins/ASHAs to be invited and from there they would together visit a family where they have heard that a wedding is being arranged for a 14 year old girl and try to dissuade them. They would talk to a number of other women during the marriage and get them to join in for the visit. Before they go to the house they would have a joint meeting with the local women.

Later in the next month there is also a sammelan of Mitanins/ASHAs to be organised in the block and there was a discussion of what preparations they need to do to go for the sammelan.

Discussion on Case Studies 1 and 2

Is it that in the second case-study Mitanins/ASHAs are motivated and therefore can be mobilised or that because they are doing a number of collective actions – singing, special claps, attending a friendly get together , attending a marriage, going to a family together to stop and early marriage – they have been mobilised and therefore they feel energised and motivated. The skill of the trainer is in having constructed so many things they can do together that do not seem like tasks, but still effectively gives them a sense of purpose, a sense of "wanting" to do these things- which taken together is mobilisation. Also note how attending a marriage, attending an ASHA meeting, womens meetings, collective action of Mitanins/ASHAs acting together, collective action of women in the community acting together can all become integrated- or be done separately.

> **Mobilisation is not a one time activity. Social mobilisation is essential to keep the spirit of voluntarism and action on behalf of the community together. Social mobilisation is essential for continued community support and ownership of the programme.**

The key to successful mobilisation? When health workers are organised, supported, and energised, the accomplishments can be great. When they are fragmented, torn apart by multiple tasks, or demotivated, mobilisation efforts will fail. The fragmentation of worker efforts can be worsened when separate mobilisations have disconnected training programmes or competing incentive payments.

ASHA AS A COMMUNITY MOBILISER,AN INITIATOR AND A LEADER

In a village of Angara block, Ranchi district, the Sahiyya organised a group of youth to build a soak pit next to the bore well so that the stagnant water next to the hand pump did not breed mosquitoes.

In the villages of Parinche block, ASHAs along with womens health committees and self help groups decided to impose a ban on drinking alcohol in their villages.This was decided over a number of meetings and the women took turns to inspect the houses and public places and see that the ban was observed.

In the villages of Sonahattu block the womens health committee decided that there would be no marriages allowed in any family where the girl was less than 18 years old.They went as a group and informed every family of the decision, taking their consent and then got it passed in the Panchayat.

In the villages of Tahabarpur block the ASHA took a delegation of women to meet the Chief Medical Officer to complain that they were being charged for deliveries at Rs. 400 per delivery if they went to the hospital – though it was said to be free.

In the villages of Dohrighat block the ASHA decided to organise a self help group which would also undertake the task of making and serving the noon –meal at the local school.

There are many stories like this from the places where ASHAs/CHWs are working.
What do we learn from this?

That the ASHA is not selected by a community made completely aware by social mobilisation. On the other hand once selected, by virtue of her sense of solidarity she becomes the person to lead the community and build a sense of organisation. She becomes the person who mobilises the community. In some places such mobilisation occurs spontaneously. But in most villages such mobilisation requires facilitation – and the ASHA's primary role becomes a mobiliser and organiser of the weaker sections of society to secure their rights and take charge of their own health.

Some officials read the ASHA document of the NRHM and tell us – but this is not what the government guidelines say. Other officials read the ASHA document of the NRHM and tell us – this is exactly what the government guidelines mean.

The moot question is, what does one understand from these guidelines?

CASE STUDY

The Experience of Dr. Arole in Jamkhed and Dr Antia's work in rural Maharashtra was presented before an audience of officers in a district. The senior presiding officer stated, "this is alright. It will work when we have a dedicated person like Dr. Antia or Dr. Arole to lead this programme. But you do not know the officers in my district. I can hardly get them to do their routine work. And the local NGOs are even worse fellows. So how can I do it here?"

It helps to think of it like this. The motivation of people in any group varies – like all their characteristics vary - probably they would define a bell shaped curve.

However the systems we need in place must be such that for leadership roles we can select out the most motivated – the top 5% – and place them in charge. That means to be flexible on the rules – allow a lot of people to have some opportunity to contribute and promote to leadership roles those who show the most motivation. And once many such people have been found stabilise the group and concentrate on building their capacity.

But still the motivation of the group as a whole depends on determinants- the background of peoples activities that have taken place earlier the level of community spirit prevailing etc. However by a process of good social mobilisation we can shift the curve to the left – that is increase the motivation levels of the group as a whole - and we can sustain it there by constantly keeping up social mobilisation.

RESOURCES AND TOOLS OF SOCIAL MOBILISATION

The Content of Social Mobilisation needs planning :

The core messages which are mobilisational need wide dissemination. Building the core messages is a task that needs special attention. Given below are a number of examples of core messages that were developed in different places for the ASHA programme.

- People's Health in People's Hands.
- Health is a Basic Right.
- Education, Health and Nutrition: these are the rights of every child.
- In happiness, everyone comes, but in sorrow, your Mitanin does. *(This is a local proverb in Chhattisgarh.)*
- ASHA, a friend of the poor, a friend of the sick.

These are all simple slogans which in various ways capture the spirit of the campaign. Once this core content is determined then they are used to build a favourable environment and this requires not only slogans put up on posters and wall writings, but songs and poetry that can capture the spirit of these messages and disseminate them widely.

The *Kalajatha* and the use of Local Cultural Media

These are some of the best media for social mobilisation in the Indian context. The *Kalajatha* is a traveling troup of artists who are trained to perform a number of songs and skits, usually in street theatre or folk theatre format. The team travels from village to village giving these performances. Much of the success of the *Kalajatha* depends on developing the core songs and skits with high aesthetic quality and capturing the spirit of the campaign. The successful use of cultural media is a focus on touching people's hearts and making them think and reflect on their own attitudes – often by provoking fun on it. Though it can be used for conveying information on health care – like immunisation schedules- this is a very secondary purpose- and better avoided.

The focus should be on the spirit of the programme. When the programme is explained by officers and functionaries very often the spirit of the whole programme – the empowerment content does not go through. How for example can we expect an ANM or the local medical officer to raise the issue of health rights when they are themselves complicit in the processes of its denial. How can we expect even an NGO to raise the issue of health as a right without provoking a hostile response. How can we discuss power structures of the village without provoking local hostility? The experience is that well crafted plays can raise these issues, energising weaker sections to participate and a common message on such issues can be spread by the *Kalajatha.*

Once a set of plays are developed then one trains a number of trainers (play directors), each of whom trains a troupe and travels with it.

The other part of the success of the *Kalajatha* rests on using it to create a public function in the village, hosted by the community preferably at its expense , involving all sections of the village and the use of the stage to introduce the whole programme. The participation of different sections of the village in a programme with such a content builds the consensus for the programme and accords it with local social recognition, reaches the messages to the women and brings forth a number of potential volunteers.

One could also ask for each village to prepare its play and this is a creative exercise- but it would serve a different purpose. The commonality of the message, the building of a socially shared understanding of the empowering nature of the programme would not be achieved by this.

Participatory Rural Appraisal

It is primarily a tool of situational analysis. But it can be used as another excellent technique of social mobilisation. This PRA is useful even in the selection process to do a gender and poverty analysis and identify weaker sections before the selection is made. And after selection it is useful for planning and monitoring programmes. The PRA is discussed in detail in the second book on community participation.

HOUSEHOLD SURVEYS

These too are primarily data gathering tools used for making a situational analysis and identifying and quantifying health needs. However these can be used as vehicles of social mobilisation. These are discussed along with village health planning.

Village level meetings & local – block or district level conventions are excellent forms of social mobilisation. In the usual village meeting the facilitator has to go to every house and call women or men to attend the meeting. This involves discussion in each house before and during the meeting. By fixing a time for the meeting in advance, arranging for a person from outside to come, and, at the appointed time, going house to house to mobilise a turn out – people get involved.

For a convention outside the village, a notice/pamphlet may be prepared. Then this has to be given to each house and each family canvassed to attend it. The programme of the convention needs to be attractive enough and the person taking them along must be persuasive enough for people to be mobilised to attend the convention. This sort of mobilisation also depends on the pattern of relationships people have with each other in a community –so some persons can get it done and some people cannot – at least not as easily.

Social Mobilisation requires involving as many people as possible in the area.

One implicit understanding of community or social mobilisation is the emphasis on involving diverse groups and organisations. In the next chapter we shall look at the different groups and their potential for involvement in the process of social mobilisation.

Social Mobilisation needs a budget

Kalajathas cost : Holding meetings with facilitators cost. Holding conventions and conferences cost. These need a budget. The ASHA programme provides for a social mobilisation budget. But since it does not detail what it really is, this item is often spent on all sorts of other activities.

Limitations of Social Mobilisation & the Need for Building Organisations and Institutional Structures

By nature mobilisation is transitory. It is in the nature of a campaign – often almost synonymous with saying a campaign is being conducted. A campaign works as long as the attention of a number of people can be drawn and focused on the purpose. But a campaign cannot be maintained for a length of time. People from different sections would have different priorities and would have to get back to them. Also in a sector like health care, there are a number of activities that must happen on a regular basis and frequently.

Thus if a series of health melas are held they have a very good mobilisational effect. People get interested. They come in large numbers.They get some definite and immediate benefits. A wide variety of sections of the community are involved. Unfortunately they make little difference to health status or even service delivery. Social Mobilisation is not an end in itself. Even as behaviour change communication they have little effect. Unless it is followed up by sustained activity – which always needs organisation and institution building.

Social Mobilisation is not a substitute for organisation or for creation of Local Institutional Structures. Social Mobilisation can be used to initiate organisations. It can be used to energise organisations. It can be used to initiate new programmes- but seldom can it be a programme by itself – not even a behaviour change or IEC programme. Social Mobilisation may be necessary for creating changes at the community level – but by itself it is seldom sufficient.

> **"In the context of community health worker programmes, social mobilisation is necessary to get all sections of the people interested and involved in selecting the community health worker, in supporting the community health worker and above all in ensuring that a community health worker is not a stand alone worker but an organiser of collective action by the community."**

For changing health practices and improving utilisation of health services is not something that a CHW can do by herself.The entire community has to act- and a community can act only through organisational structures. If the work required is to be sustained over years and requires increasing capacity then it requires going beyond organisation to institutionalisation.

In the next lesson we shall look at various organisational and institutional structures that can effect community participation and the role of the ASHA in relation to this.

Review Questions

1. How does the term community mobilisation differ from the term community participation?
2. Why is community mobilisation essential to the outcomes of many health programmes?
3. ASHA is the outcome of a community mobilisation process-but one of her main roles is community mobilisation? Discuss.
4. What are the different tactics of community mobilisation?
5. What are limitations of community mobilisation?

Application Questions

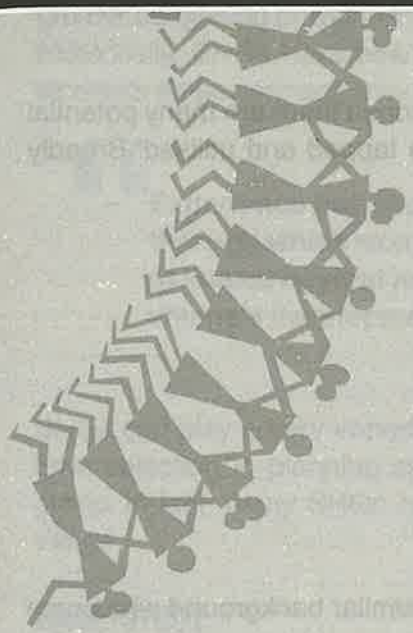
1. Community mobilisation , differs from organising the community and this in turn is different from creating community level institutional structures. What would be appropriate at different stages of the ASHA programme? How do these relate to the elected Panchayat.
2. Community mobilisation and institutional structures are also essential for a number of other programmes – like self help groups, access to elementary education, food security etc. is there a scope for convergence at the level of mobilisation, at the level of organisation and at the level of institutional structures in these areas if intervention?

Project Exercise

1. With reference to community participation? With reference to ASHA programme? Draw up a budget for the ASHA programme in your district based on the budgetary allocation of the NRHM.
2. What are the social or community mobilisation requirements for the following – to be reflected in the district plan?
   - With reference to child survival and safe motherhood programmes? (to do this task with reference to Books 2 and 3).
   - With reference to disease control programmes? (to do with reference to Book 8)
   - With reference to BCC programmes? (to do with reference to Book 5)

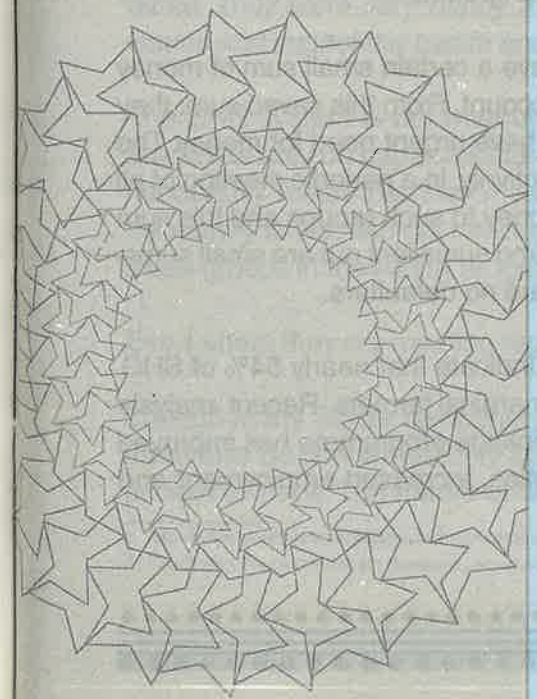
Lesson SEVEN

Village Level Partners in Community Participation



In this lesson we shall discuss:

- Who the potential partners for village level community participation are.
- The characteristics of each partner and their potential and limitations in contributing to community participation in health.



INTRODUCTION

The ASHA does not function in isolation. Indeed she cannot function in isolation. She needs to be supported by village level processes.

The ASHA is not the only possible vehicle for community level activities. Indeed there are many potential partners and resources that are available in the community that can be tapped and utilised. Broadly these can be categorised into four types:

a. Community Based Organisations
b. Peripheral government or quasi government employees
c. Panchayat and related bodies
d. Politically linked organisations

COMMUNITY BASED ORGANISATIONS

Self-help Groups

A Self-help Group or SHG is a group of women (and sometimes men)of similar background who come together in a formalised/incentivised space for accessing financial services and economic power for women. SHGs may be formed by the Government through ICDS workers or *Gram Sevaks* or by NGOs and other non-profit institutions. Whatever their origin, they remain part of the civil society. The past decade has witnessed the emergence of many microfinance approaches, most notably, a nationwide attempt, pioneered by nongovernmental organisations, and now supported by the state, to create links between commercial banks, NGOs, and informal local groups -"self-help groups,".

A self help group is typically an organisation of about 20 women, who save a certain small sum of money every week or every month, depositing this amount in a common bank account. From this saved sum, they advance loans to themselves, at a fixed interest rate, when one of them have urgent need for money. The decisions on how much to save and whom to give loan to, are taken collectively, in a periodic meeting of all the 20 women. This may be weekly, fortnightly or monthly. Banks lend money to such groups and this sum taken from the bank is lent out to the members. Typically the sums saved and sums lent out are small sums. Repayment of loans is excellent with peer pressure ensuring that there are no defaulters.

Today there are approximately one million SHGs across India.[1] Surveys indicate that nearly 54% of SHG members are from the poorest groups[2]— these include the landless and marginal farmers. Recent analysis has shown that access to loans for poor households under SHG Bank Linkage programme has improved asset position, increased savings, shifted borrowing patterns and activities, increased employment and

1. NABARD
2. http://www.worldbank.org/wbi/reducingpoverty/docs/newpdfs/case-summ-India-ScalingUp-RuralPoor.pdf

consumption expenditure and had a positive impact on income, as well as a beneficial social impact.[3] Though SHGs are organised around the rationale of financial services, the processes of group formation and interaction may foster individual development and in turn translate into external changes – such as greater bargaining power in the household, leadership within the community, higher awareness levels etc.[4] Historically, SHGs have been a major part of women's movements and have been seen as a tool for women's empowerment, making them more control over their finances and concerns.

> **Experience has shown that SHGs can be a very powerful collective in the village through which women in particular can assert themselves and address a number of issues beyond just finance, and indeed relating to their empowerment and the village's development.**

SHGs can play a very important role in village processes involving health and the ASHA programme, from selection to planning and support/monitoring and from being a discussion group to a pressure group. In fact, many SHGs can easily take up the role of a women's health committee in a particular village.

CASE STUDY

Shakti Mahila Samiti is an SHG in Salhi village in Rajnandgaon district. They have been active in taking up issues of women's rights like alcohol prohibition, in the village. When a ASHA Facilitator/ Prerak came to their village for selection of the Mitanin/ASHA, the SHG members got together and along with other women of the village, selected the Mitanin/ASHA. They also reiterated that the Mitanin/ASHA would not have to work alone. They were very happy that now with other issues; they would be able to discuss women's health issues and impact the health and nutrition status of their children.

The SHG system is not without its problems. Due to the *sarkarikaran* of SHGs, in many villages there are SHGs only on paper without any actual meetings going on. So just having an SHG in a village does not necessarily mean that they meet regularly or that women see its role in their empowerment. It would be necessary to first find out how functional an SHG is, before using them as Women's Committees. Involving these groups in the ASHA programme can also be a way of revitalising them.

Even where they are meeting regularly the poorest and most marginalised and suffering may get excluded.

Though many SHGs have shown commendable initiative in addressing peoples issues, the majority of them may be concerned only about the interests of its own members and that too limited to the issue of access to loans. The nature of leadership for these committees makes a big difference on whether these

3. http://www.worldbank.org/wbi/reducingpoverty/docs/newpdfs/case-summ-India-ScalingUp-RuralPoor.pdf.
4. Credit with Education Impact Review-1, Women's Empowerment- Barbara MkNelly and Mona McCord.

can take up empowerment roles. Where such groups are federated and supported by civil society groups or government officers committed to womens empowerment the SHG is better able to reach its full potential- but this unfortunately is not the case in most SHGs.

Despite these problems, the SHG is often the most stable, self –conscious, organisation of poor women that we can find in most villages. Involvement in health programmes helps them to go past their limited understanding of their roles and gain a leadership role for themselves in the community. Health programmes benefit because there is an existing organisation to link up with, which organisation is likely to be more stable then any organisation build up only for the programme.

WOMENS HEALTH COMMITTEES

Most community health volunteer programmes have found it necessary to support the community health volunteer with a womens health committee. In the Mitanin programme, the Women's Health Committee (WHC) is a hamlet level committee formed by the Mitanin. In some programmes like the Sahiyya programme in Jharkhand, the women's health committee is formed first and it selects and supports the ASHA. In the ASHA programme too it is essential to constitute such a womens health committee.

The WHC ideally consists of most women of the hamlet. The meeting of the WHC is the most critical component of community participation and a space for social mobilisation. The WHC should meet once every week but in practice it tends to meet once every fortnight or even once a month. Initially, it is the trainer who facilitates the meeting. But after a few months, the WHC is able to meet, discuss and plan on its own with the ASHA as the convener. During these meetings, the ASHA shares all the information given to her in the trainings. The WHC then discusses those issues and plans for future action. The role of the WHC is to support the ASHA and build a consolidated force of women which can negotiate on health and other issues at least the hamlet and Panchayat levels. It is the strength of this WHC which would determines the efficacy of the ASHA programme as a vehicle of community participation.

CASE STUDY

Biharpur Primary Health Center was a non-functioning PHC that used to open only on the local bazaar/ haat day. The only PHC doctor lived 59 kms. away and the peon usually ran his own private practice. There was an average of only 2 patients per day who came to the PHC. Patients had to pay up Rs.10 instead of the Rs.2 user fee. Indeed, people had stopped going to the PHC. The ASHAs of that area discussed these issues in WHC meetings. The ASHAs and the WHC members of surrounding villages went together to the PHC, talked to the doctor about his irregularity and subsequently approached the District Magistrate and Block Medical Officer against him. Since then, the doctor now comes regularly and there has been a steady increase of people going to the PHC and demanding services. The peon has also stopped his private practice.

Discussion

How best can the role of the ASHAs in this initiative be described? What was the role of the WHC? What do you attribute the success of this endeavor to? If ASHAs are selected by the Panchayat sarpanch or the ANM can they be expected to play this role? If however they are guided to form and make functional such WHCs, will such a role emerge for ASHA even where she has not been selected by the community.

The ASHA is a leader who organises and mobilises women to actively intervene and speak out. She brings information and spreads awareness in the village. But what she can achieve is directly proportional to the amount of active support of the other women in her village. By recognising that the village community is not homogenous, it is essential for the ASHA to see that the more marginalised sections of the community are facilitated to speak out and participate in village events, activities and meetings.

When women act together, they are heard. The WHC along with the ASHA first tries its hands at small things like ensuring that the ANM visits the village regularly, that the Anganwadi center is opened daily, that pregnant women are coming for antenatal care. Once these things start happening, it builds the confidence of the group. The true test of effective womens health committees is that they do not stop at the issues they were organised for – but go on to tackle other issues that affect them -like domestic violence, child marriage, alcohol prohibition and active participation in the Panchayat.

When women from the weaker sections of society organise into such a group, it gives them the power to assert themselves and make themselves heard; something which they had been deprived of till then. They become actors in determining and intervening in their own future. The WHC is a consolidation of women power and holds numerous possibilities for initiating a social movement.

CASE STUDY

In Rokda village of Koriya district, the Mitanin saw a drunken man hitting his wife mercilessly. She immediately gathered women and a few men and they managed to save the woman. In the next WHC they discussed the need to take some action condemning such acts of violence. So they decided that since drunkenness is made out to be an excuse for inflicting violence by men, they will use any act of domestic violence as an excuse to destroy liquor. They then moved around the whole village, searching each house, destroying all vessels in which mahua liquor is made and stored and pouring out liquor from liquor bottles. They did not rest till they had searched every single of the hundred odd houses in the village and till every single drop of mahua liquor in the village was destroyed. After that day, the Women's Health Committee made a resolution that every time there is an incident of domestic violence typically related o a drunken man beating his wife, then on that day the women will destroy all the liquor in the village. It worked and to this day it is working.

The WHC has certain problems. Firstly, it is not a statutory committee – in the sense that it is not recognised by the government or the Panchayat. So what it says need not be listened to and often they are indeed ignored. However if it were made statutory and given powers it would not be freely able to include all those who want to become members. The local elite would want to determine its composition and many women would not get the chance to participate. The solution probably lies in keeping the WHC as an informal, hamlet level womens health committee and then giving it representation in the formal statutory Panchayat level or village level Health and Sanitation Committee.

If on the other hand it is an informal committee, it is difficult to keep meetings regularly and keep it functional. So often the committees are formed, meet a few times and then they stop functioning. This requires leadership skills that the ASHA or even her trainer may not possess. But if the trainers are well supported they would in course of time acquire such skills and pass it on to the ASHAs. This takes time. However such constant external support is needed 'in perpetuity' for the WHC to be functional- it does not run of itself. The day it starts taking up many other issues in the village at its own initiative then it has truly stabilised but now it would need support for being able to address these issues better – or else it would get demoralised and stop.

Those providing support should also have a feel of how such village organisations function. Such experience at district level is so poor, that they fail to provide the leadership needed. However if an NGO with good grassroots experience is added into the leadership outcomes are often better.

YOUTH CLUBS

These are groups of youth who have come together for some activity like games or organising particular festivals etc. They are the future adult actors of the village. Involving them in the ASHA programme increases their awareness on health issues and sensitises them, especially on issues of women's rights, violence against women etc. This will prove invaluable for the future wellbeing of the village. In working with youth groups one has to keep in mind that most youth groups consist of boys. Though it is desirable for girls to be included one has to see the local context , and places where such a club may be largely providing a peer forum for male youth, the space to make such changes may not exist. The Youth group can get involved in various activities. Some examples are given below:

- The youth groups of Sakhiguda village in Koraput district, facilitated by the ASHA contributed to malaria prevention by digging soak pits near the tube well, filled pits which were breeding grounds for mosquitoes and weekly took turns to pour oil into pits which they could not fill up.
- Adolescent girls group organised by ASHA of Jamjunga village in Sarguja district visit the Anganwadi center daily to play with the children, teach them songs, poems etc.
- ASHA and the WHC of Kachua village of Raigarh have planned with the youth group of the village to act as messengers so that they are able to bring in referral transport as soon as possible, when any pregnant woman or serious patient requires it.

Youth groups act because of the restless energy that such youth have and their need to do something that brings them recognition and gives them a "feel-good" factor. Again channelising this energy and securing them their sense of achievement, requires skilled leadership.

The other problem with youth groups is that they vary widely in composition, goals and potentials for working in community health programmes. No single order can capture and do justice to this diversity - a reason why such groups are often ignored in government planning. But with more space for negotiating local support and participation, peripheral functionaries can find the right mix.

RELIGION OR FAITH-BASED ORGANISATIONS

There are a large variety of such organisations. Most such organisations do not lend themselves to such work- as organisations. In mixed villages they could also be exclusive. They are concerned largely with holding festivals and taking care of the place of worship. However individuals associated with such work- not as formal leaders but those who do the actual work- may be generous, public minded and may want to contribute to any " good work" in the village- their current engagement with the temple being only an example of such "good work." They are also well connected and useful to have on the ASHAs and WHCs side. There are many behaviour change messages of the ASHA where their support is even more important. The age of marriage is one such issue.

One also needs to differentiate between 'community-based' or 'religion-based' organisations and organisations which are 'branches' of large state or nation level religion-based political formations. The latter have a distinct agenda of their own and normally do not encourage other agenda except when they can draw upon it for their limited objectives. These can cause considerable resentment in those who do not share the same religious views and it is best that they are not central to the programmes. However many of the individuals would need to be negotiated with as important individual decision makers.

PERIPHERAL GOVERNMENT EMPLOYEES AND LINK WORKERS

Anganwadi Worker and Sevikas

The Integrated Child Development Scheme (ICDS) is a major Government nutrition scheme for children under six years of age, and hence the ASHA has to work very closely with the Anganwadi (ICDS) Workers and Sahaikas. The aims and objectives of both are the same and their roles are complementary. The Anganwadi Worker and the ASHA play very similar roles in supporting the ANM to provide immunisation and antenatal care (ANC). The ANM comes to an anganwadi center once a month to provide immunisation services to children and ANC to pregnant women. Earlier it was the duty only of the Anganwadi worker and Sahaika to gather the pregnant women and children. The Mitanin's role in convincing women to come for vaccination and getting women and children from the hamlet to the center has greatly improved the efficacy of this activity.

Just as the ICDS focuses on nutrition, the ASHA too is expected to make home visits for nutritional counseling. In places where the Anganwadi worker and ASHA work well together, it is safe to assume that there will be better results with regards to nutritional status of children. There is more scope in strengthening the relationship between the ASHA and the Anganwadi worker where the worker performs her duties well.Whereas the focus of work of the anganwadi worker is her "center" or "Kendra" and the mothers who come there- the focus of ASHAs work is the doorstep or angan of the family. At the family level the ASHA interacts not only with the mother, but with the husband and in laws- crucial players in decision making- whom the anganwadi center cannot reach. Also the marginalised and excluded are priorities for the ASHA in her home visits. The ASHA is also in a better position to articulate health rights issues and access to basic entitlements. In all of these tasks she therefore complements the anganwadi worker.

> **"The major challenge is to build a positive partnership between the Anganwadi worker and the ASHA and WHC. The women need to build bonds of kinship in the fight against larger evils."**

CASE STUDY

In Basla village of Mainpat block, the Anganwadi worker is irregular in opening the Anganwadi, one reason being that she stays 15 kms. away from the village. The ASHA and members of the WHC are aware about the importance and provisions of the Anganwadi and realise that the Anganadi in their village is not functioning well.

What should they do? Discuss in the light of following statements:

- The Anganwadi worker is the lowest paid staff in the whole system and most approachable to the villagers, hence most likely to be victimised
- The children of that village are losing out on critical supplementary nutrition and pre school education.
- Women should stick together and if the WHC and the ASHA intervene, it will be a case of one woman versus another, and the ASHA may lose out on the support of the Anganwadi worker.
- Being provided with supplementary nutrition is the right of pregnant women and lactating mothers.
- Women being able to assert their rights show that community mobilisation has been successful and the WHC is strong
- Community participation should not result in conflict situations
- The Block Medical Officer (BMO) does not want the Health department to come in conflict with the Women and Child Development department.

CASE STUDY

In Hanspur village of Manendragarh block, the Anganwadi worker was irregular in opening the Anganwadi centre. One day, the Mitanin along with members of the Women's Health Committee went to the centre and asked her why she did not open the centre regularly. The Worker told them that as the various hamlets are scattered afar and too many, the Sahaika can't gather all the children everyday and also the parents themselves don't send the children. Often no children , except from the nearby houses came, and therefore she did not make any effort to open it daily. The women told the AWW that the perception amongst parents was that often they made the effort of sending the children only to find the center closed. The Anganwadi worker said that she would be regular from then on if she had their help in bringing the children in. They also decided that in the coming week, the members of the WHC along with the Mitanin and the Anganwadi worker and Sahaika will take out awareness rallies in the various hamlets, informing the parents of the importance of and the entitlements in ICDS and encouraging them to send their children. Each WHC woud ensure that children from their hamlet attended. The Sahaika also agreed to gather children from two of the hamlets where such assistance was needed as the families had to go to work.

ANMS & MPWS

Of all the government workers who come into the village, it is the ANM who can be the closest partner of the ASHA. Nearly all of the village level government health services are routed through the ANM. Hence she is a very critical player in health issues of the village. Therefore even in the ASHAs effectiveness she is the essential input.

The ANM benefits, because ASHA acts as a link between the ANM and the community. The ASHA refers complicated cases to the ANM, helps her in immunisation, and gets her medicines restocked. She supports the ANM by providing information and mobilising the community to use the services.

The community and especially women, if the ANM is able to gain their confidence, will participate and support the ANM in all health programmes and campaigns, and together improve the health status of the villages. The ASHA as coordinator of the womens health committee plays an essential role in forming this bond.

There is the danger of the ANM and the health system transferring a number of their tasks to the ASHA. The ANM can just request the ASHA to help her, not demand it. The trainers and block level programme staff need to be very diligent in ensuring that that does not happen. The ANMs and MPWs need to be regularly reminded that the ASHA is voluntary and can give only a limited amount of time and shouldn't be forced to do more work. If more work is required, it should be discussed and negotiated with her and she should be compensated for loss of wages due to time spent on this work. She should not regress into being the lowest level government functionary.

CASE STUDY

Bairagi village of Manendragarh block is a remote village which is accessible only by trekking 10 kms. Here, soon after the Mitanin/ASHA was trained on child health, she realised the importance of immunisation and that there was a huge immunisation gap in her village. She met the ANM in the weekly bazaar and requested her to come to the village. The ANM told her that the children and pregnant women refuse to get vaccinated in that village and that she was scared to trek alone. The Mitanin/ASHA told her that she will ensure that the children and women come for vaccination and also fixed up for the ANM to come with the school teacher who used to go to the village daily. The ANM gave her a date for immunisation in the village.

In the village, the Mitanin/ASHA identified children and pregnant women who had not been vaccinated. She spread awareness about the importance of vaccination and tried to do away with people's negative perceptions. When the ANM came to the village, the Mitanin informed and gathered all the children and pregnant women. This led to a steep rise in immunisation status and regularity. The ANM, who was initially very skeptical about the Mitanin's work, realised the Mitanin's potential in mobilising the community on health issues.

When incidents of gastroenteritis were on a rise, the Mitanin/ASHA immediately informed the ANM who camped there and with the help of the WHC members was able to prevent an epidemic from breaking out.

The Mitanin/ASHA, now along with the WHC members are negotiating with the Panchayat to buy BP machine, stethoscope and weighing machine for the ANM. They have already ensured that the ANM does abdominal examination of pregnant women.

Depot Holders

The Government has appointed Depot holders (volunteers) for every village who are given medicines like chloroquine, primaquine, paracetamol and ORS. They are usually the Ward Panch/Member, Sarpanch, Anganwadi Worker or School teacher. They are supposed to identify patients and give them medicines, mainly for malaria and gastroenteritis. Though this programme has tried to ensure that these basic medicines are available at the village level, experience shows that the Depot holders have failed to have any significant impact on combating these diseases. The idea was too simplistic in its approach, as we all are aware just stocking up medicine in a village is not enough to deal with the health issues of a village. But as we have learned, this is not enough and reasons for the failure of this programme mainly revolve around the total disregard for community participation.

Let us look at the reasons further at the experience of depot holders as it has learnings for the ASHA:

- There was no community participation in selection, no awareness building or knowledge sharing, hence there was no attitudinal change and the people preferred to go to the quack.
- The Depot holders were people in power or closely linked to them. Being in charge of the medicines was another way of clinging to resources which did not percolate to the needy. Often if they got enough medicines for their family needs they did not bother further with their role
- The community did not have any ownership over the programme and there was no motivation for the Depot holders to work.
- The Depot holders were not given any training. They lacked knowledge even about proper doses. The drug was merely an instrument of patronage and control
- In many villages, the community was not aware of their presence, especially the weaker sections of the village.
- There was no concept of monitoring by the community and more so because the Depot holders were already powerful people.

In Chhattisgarh, ever since the Mitanins started distributing medicines, the Depot holders as they were, are becoming redundant. This is a welcome development though there are many instances of depot holders who have done good work, for it helps organise community outreach much more systematically as part of the Mitanin/ASHA programme. The Government now recognises the Mitanins as Depot holders. However since they have local influence many of the depot holders not only survive but managed to get the drugs that should go to Mitanins.

By the NRHM directives, all ASHAs will have the function of depot holders- and therefore in most situations other depot holders would be redundant.

School Teachers

As there is primary school every one kilometre and an elementary school every 3 kilometres, the school teacher can become a critical agent for supporting community initiatives such as the ASHA programme. Winning the teachers support for ASHA is a useful step. The teacher can not only help in mobilising children in their teens on issues of health and nutrition in their villages but also participate to organise immunisation day, nutrition education competitions, and marking the relevance of good health and hygiene in the village.

Child-to-child health education and even child-to-parent or child-to-family health education are approaches that have demonstrated to work. School children are also vulnerable to disease and there is a need to have appropriate school health programmes. This is covered in Book 8 on Convergence.

PANCHAYATS

The Panchayat's role in the ASHA programme is manifold. It is involved with the programme from the beginning. Its role is in planning, monitoring and supporting the ASHA and the WHC in their endeavours.

The selection of the ASHA is ratified by the gramsabha. The gramsabha is the basic unit in the Panchayat structure which includes all adult men and women of a village. This is the most representative body of the village, provided all sections, including weaker communities and women participate. Since in practice everyone does not speak up – and it is even considered disrespectful for women and weaker sections to speak up let alone disagree with dominant families- there is much facilitation needed to voice the concerns of weaker sections. Despite this the gramsabha is the most basic of democratic units and even where it is not functional, this could be an opportunity to make it functional.

Once the gram sabha selects it the Panchayat committee has to endorse it. It does not have a choice – but it is important to record it in the minutes.Where there are many gram sabhas in a gram Panchayat the Panchayat may land up opposing it – but then the village would have to negotiate a consensus or go to a higher authority. It is important to try – as far as possible – to take the Panchayat along.

Thus the role of the Panchayat starts along with the initiation of the programme.

> **"The gramsabha is the basic unit in the Panchayat structure which includes all adult men and women of a village. This is the most representative body of the village, provided all sections, including weaker communities and women participate."**

The Panchayat can address a number of health and food related issues. Issues like regularity of the ANM, proper functioning of the Anganwadi, mid-day-meal, ration shops and Janani Suraksha Yojana, prevention of malaria and gastroenteritis etc.

The problem which the ASHA and the WHC may be faced with is that mostly Panchayats do not see health as their mandate. There are supposed to be Panchayat level health and sanitation committees which are never formed. Once the WHC starts discussing health issues in the Gram Sabha and in the Panchayat meetings and demands action by the Panchayat, the Panchayat will slowly get sensitised and start planning for health issues. They along with the ASHA and the WHC can identify the gaps and plan along with the Panchayat to fill those gaps. Panchayats, even the worst of them, have to be responsive to people and what they want. To the extent that the ASHA makes a " want " popular and well articulated by people the Panchayats support would be forthcoming. Many newly elected Panchayat leaders actually

look for opportunities to do something good for their people and welcome suggestions from ASHAs on what can be done.

Some examples of successful collaborations between the ASHA and Panchayats are given below. These examples are taken from Chhattisgarh, but there are such events from many of the ASHA programmes.

- In Patna Panchayat of Baikunthpur block, during the Panchayat planning exercise it was realised that most of the children were malnourished. This data was shocking for the community. It was also found that very few children were availing of the Anganwadi services as there was only one center among 7 villages. The Panchayat agreed to demand for Anganwadi centres for all the villages. Till the centers were opened, the Panchayat started a feeding programme in all the hamlets from their funds where hot cooked meal was provided to all the children below six. They also made provision for providing dry rations of rice, pulse and gur for children who were too small to come to the centre. It was decided that the ANM and Sarpanch will jointly request the Pediatrician from the CHC to hold a camp in the Panchayat. The Mitanins along with the members of the WHC and the Trainer will visit every household for nutritional counseling and there will be compulsory monthly weighing of all the children below 6 years. To facilitate that, weighing machines will be bought for every village from the untied funds.
- In Anandpur Panchayat, the Mitanin/ASHA and the WHC undertook planning on malaria prevention with the Panchayat. Panchayat funds were used to fill all the ditches before the monsoons and gambusia fish was brought to breed in the local pond. The WHC negotiated along with the Sarpanch at the block level and were able to get mosquito nets for the tribal families of the Panchayat. Every time he goes for block level meetings, the Mitanins inform him of the number of people who have fever and he then reports it to the BMO.
- In Dhulku village of Manendragarh block, Babulal used to beat his wife frequently and mercilessly after getting intoxicated by consuming liquor. For some time she was suffering silently. But when she could not bear the violence she decided to leave for her parents' place. The Mitanin and the WHC called a Panchayat meeting where Babulal was excommunicated till he brought back his wife from her parents' and refrained from any further violence. Babulal did indeed bring back his wife and apologised to her. Since then he has stopped beating his wife.
- In Chhattisgarh, an overwhelming number of Mitanins stood for the Panchayat elections. It is estimated that large number (approximately 5 to 6000) of Mitanins stood either for Ward Panch/ Member or Sarpanch out of which about 4000 got selected.
- In Balshiv village of Garudol Panchayat, there were two Panchayat Wards out of which only one was reserved for women. The Mitanin and the members of the WHC decided that they want both their Ward members to be women. So they conducted meetings in the village to build a consensus and got two women leaders nominated as Ward Panch/Member.

OTHERS: POLITICAL PARTIES; INDIVIDUAL DECISION MAKERS

Elected representatives of the people, including the MLA or Panchayat leaders, are powerful people in the village and need to be involved in ASHA selection- without their taking over the process.

Other influential people include members of political parties or subordinates of leaders.These may have been selected by these leaders and have little support themselves or they may command considerable support in one or other section of the people. They play an important function in that they provide an access to power for the ordinary person, (the power broker function) or some degree of protection from more powerful individuals of other communities who are inimical to them (protection function). Such leaders also provide 'leadership' in a number of political choices (leadership function) including those related to their community identity (representation function). Usually political leadership crosses with dominance in the economic and caste dimensions representing different strata within these.

Their potential is varied and depends on what sections they represent and the over all strategy that section is adopting to maintain or improve its position vis-a-vis other sections and their own needs. Thus a political leader may represent a dominant ruling section which is trying to maintain its dominance by refusing to allow anyone else to speak or a leader who maintains his dominance by actively supporting and patronising different sections. One would of course approach both of these leaders differently.

Some of the political parties have youth wings, womens wings, trade unions and farmers unions that have local branches and some of these could be very active on rights based issues which concern the economic segment they represent. To the extent that their membership is made up of weaker sections and their politics is built around such issues- they can provide much support to such programmes. But to the extent that they are using such issues for becoming the major influence in the village – with their eye on the next elections they could become threatened by the rise of organisations outside their control.

In social developments like the ASHA programme the political party seldom takes the lead but remain watchful. If the programme gains popularity they would side with it; if the programme seems to be close to their political rivals they may oppose it and so on. The point is that in many situations one can by skilful negotiation, and by the fact that the government backs this programme, ensure that there is little disturbance from such sections. Indeed there could be much support for the programme if they form a good opinion of it.

Review Questions

1. What are SHGs? What are their advantages and limitations as community based organisations to support community level health programmes?
2. In what ways do the anganwadi worker and ASHA complement each others roles?
3. What is the potential and limitations of youth groups?
4. What are the possible relationships between the women's health committee and the village health and sanitation committee?
5. Which are organisations who have limited potential to help but would need to be carefully negotiated with and won over to support the programme?

Application Questions

1. Some of the community based organisations are stand alone organisations with no links to other organisations outside that village. Others are part of networks or federations. Yet others are only local brances of a state level or national level organisation. Using self help groups and religion based organisations as examples discuss how the character of the local groups changes with the nature of its linkages.
2. There are many programmes of the government or the NGO that call for local committees of the people. The sanitation programme, the village education committee, the water users committee around irrigation, the watershed development committee, the farmers committees and department of agriculture, the milk producers cooperatives and the animal husbandry department, the trade unions of unorganised workers and so on. Which of these are relevant to your area and which of these are relevant to community health programmes?

Project Work

1. Find out the number of SHGs formed by NGOs and the Government in your area. Pick a random sample of five SHGs of both types and visit them. Is there any difference between them? Have they got involved in selection of ASHA? Can you visualise and chart their role in the ASHA programme?

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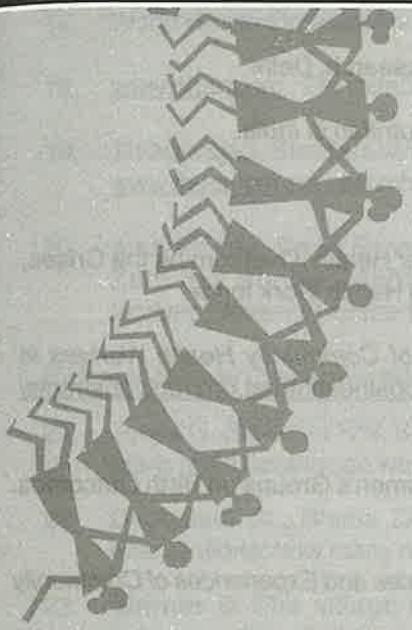
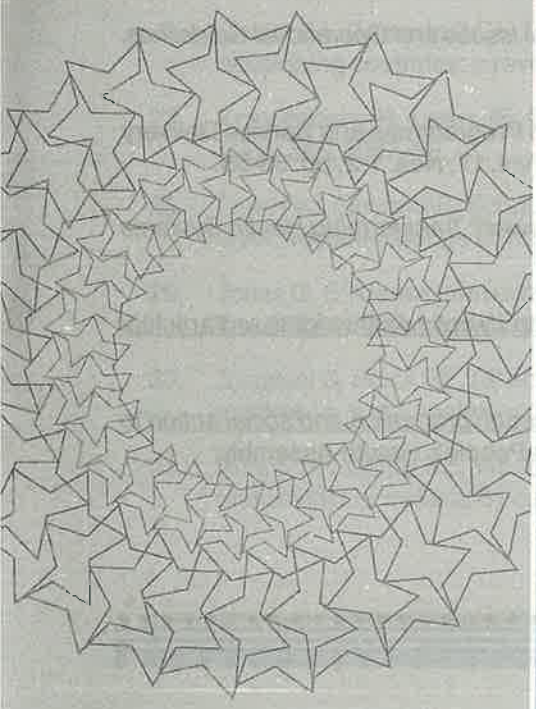
Lesson EIGHT

References, Technical Resources and Further Readings





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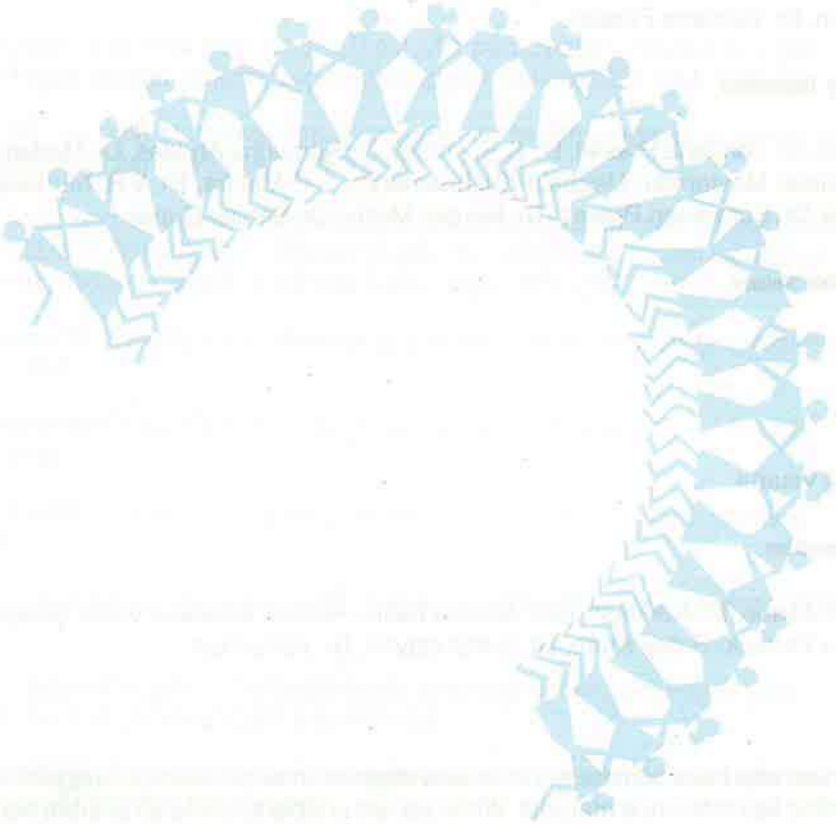

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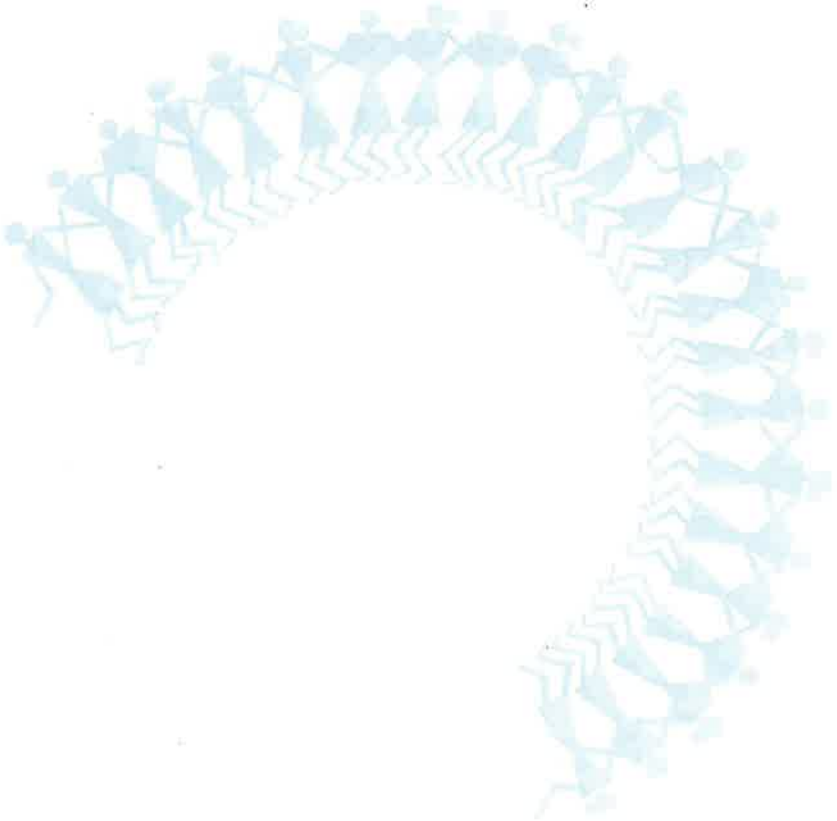

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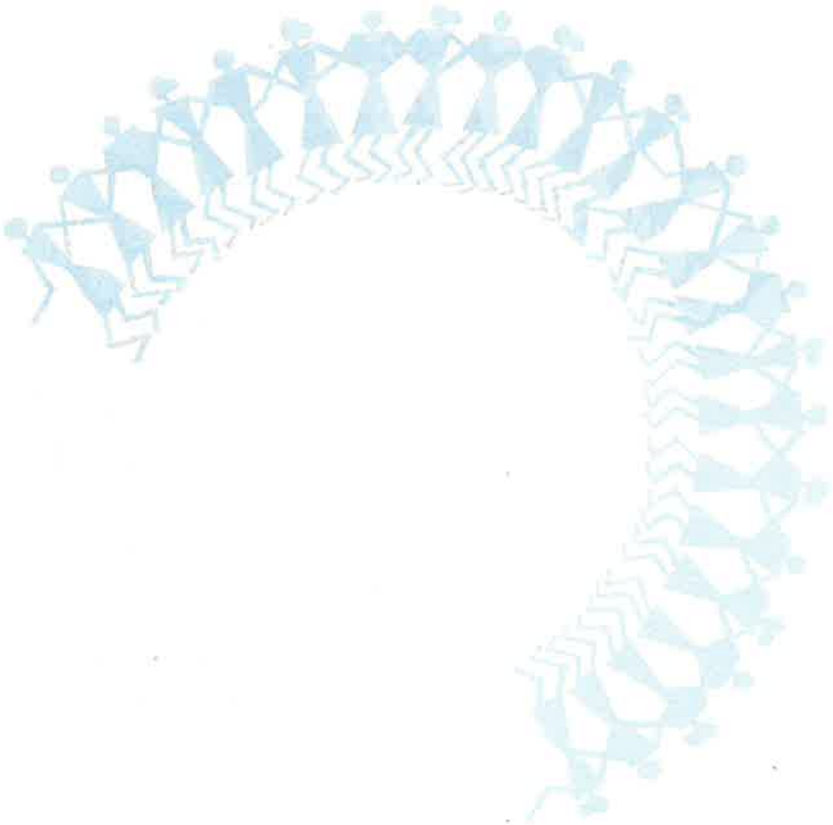

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