

Mitanin Programme

In Chhattisgarh, India

India's Largest Community Health Volunteer Programme



- **Health sector situation in the new State/ Rationale of CHVs**
 - **Conceptualization of Mitanin Programme**
 - **Design of the Mitanin Programme**
 - **Key Process of Mitanin Programme**
 - **Outcome and Benefits of the Programme**



Situational Analysis-

Chhattisgarh, one of the three recently formed states in India, came into being on November 1, 2000. Carved out of Madhya Pradesh, itself one of the weakest states in terms of social and economic development, the area that constituted *Chhattisgarh* has some of the greatest social and developmental challenges to face. *Chhattisgarh* is however one of the richest states in terms of natural resources,

One of the areas where the newly formed state lagged behind national averages, and even behind almost all other Hindi speaking states, was in public health. At the time of its creation, the Total Infant Mortality Rate of the state, for example was 79 per 1000 and **Rural Infant Mortality Rate was 95 per 1000- which was the second worst in the nation.** In comparison the all India IMR was 68 per 1000 and the rural IMR was 74 per 1000.

The government was committed to the understanding that everyone, including the poor and the marginalized, had a right to health and health care. It was also aware that the onus of ensuring that this right is realized lay on the state as well as on society. However there were many challenges to be met in order to achieve the goal of improved public health care.

There was a poor performance in all the social determinants of health. Malnutrition was high, and access to safe drinking water and use of sanitary toilets were low. In comparison to other determinants literacy had improved rapidly in the nineties. But still the literacy rate stood only at 64.7% and of this female literacy was as low as 51.9 %.

The new state had to face a very high burden of disease due to chronic communicable disease. Malaria, especially falciparum malaria had one of the highest prevalence for any state in India. Tuberculosis and Leprosy was also high. The situation in reproductive and child health was also alarming with very high maternal and child mortality rates.

If part of the causes of poor health was due to the poor situation in social determinants, another part of the crisis in public health was due to the poor delivery of essential health services.

Infrastructure Gap-

There were huge gaps in the number of health facilities sanctioned as compared to those that were needed as per norms. As per national norms the state was short by 9 district hospitals, over 30 CHCs and over 200 primary health centers and over 874 sub-centers.

The norms itself were inadequate to provide coverage for such a geographically dispersed population. Thus for example 3818 sub-centers had to cater to 9000 gram panchayats, 20,000 villages and over 54,000 hamlets. Typically a single sub-center would have to cater thus to over 10 hamlets spread over about 15 to 30 kilometers

Further the majority of health facilities did not have the basic infrastructure it needed for functionality. Only 6 out of 16 districts had adequate district hospitals. Only 34 out of 116 CHCs, only 1800 sub centers out of 3818 sub centers and only 320 out of 520 primary health centers had adequate buildings. Even where there were buildings manpower gaps crippled more than half of these facilities. Roads and transport were also scarce and this too added to the problem of access.

The new state had therefore to embark on a programme of sanctioning more facilities and then building the infrastructure and producing the manpower needed to close these gaps. But all this would take time – over a decade perhaps. And there was a need to act urgently – for the loss of life and extent of suffering such delay would cause was unacceptable. The creation of a new state had raised expectations and these had to be responded to.

Yet another cause for concern was the very poor levels of health awareness in most rural areas. Penetration of media was low. Outreach of health education had been poor, especially as there was a diversity of local languages, dialects and customs. Unchanging traditions and inappropriate patterns of health seeking and child care contributed significantly to the burden of disease. Also even where health facilities existed and were functional, utilization was low due to poor awareness.

It was for these reasons that the government decided to embark on a state-wide community health volunteer programme, there was a need to engage health volunteer who belonged to the same village and could communicate key health messages in the local dialect with an understanding of the local problems and issues. Having a health worker from within the community selected and supported by the community would ensure keen participation from both government and the community.

Community health worker/ volunteer programmes had been tried before in this area. The community health volunteer programme, the village health guide programme, the Jan Swasthya Rakshak programme had all been implemented in this region with little success. Yet the compulsions were such that the government had to choose to try once more. But this time it chose to learn from past experience and innovate to build up a

new programme design. In this the government was helped by a number of experienced non governmental organizations. ***The Mitanin programme was born out of a dialogue between the government and civil society, taking place in the context of a new state, trying to respond urgently to a crisis in public health.***

II. Conceptualization of the Mitanin Programme as part of health sector reform.

In January of 2002, the Department of Health and Family Welfare initiated a process of consultation with the leading health activists, NGOs and state officials. The department had already committed itself to a community health volunteer programme and had decided that it should be called the Mitanin programme.

The Mitanin:

Mitanin in Chhattisgarhi means friend – a female friend. In most parts of this state there exists a traditional custom that a girl of one family is bonded to a girl of another family through a simple but enchanting ritual ceremony and from that time onwards they become Mitanins to each other. According to custom any girl can always count of her Mitanin in times of need – Sukh me sabiya, dukh me Mitanin – goes the saying. In particular tradition shows her coming to aid her Mitanin in times of illness – even if it's after a long time and are married and now living in far away homes. It is this custom that was built on – to create a new type of Mitanin – the Swasthya Mitanin – the friend of the village for health care needs.

The regional office of ActionAid India was requested to coordinate the consultation and later to assist in the initiation of this programme. At a three-day workshop in January 2002, there was a consensus on key features of the Mitanin programme design and more important on the need for a massive parallel strengthening and structural reform of the public health system to make it more accessible and responsive. The Mitanin programme was not a substitute to a strengthened public health system. On the other hand the Mitanin programme would help create an enabling environment for strengthening public health systems and make health systems more responsive and accountable. In such an understanding, one of the essential directions of structural reform was the transition from the existing structure of health services to a community based health service.

Transition from existing health services and community-based health services:

Existing Health Services	Community Based Health Services
Based on technical understanding of health care	Emphasis on socio-economic and cultural aspects of health care
Centered around curative care	Stress on preventive and promotive care
Emphasis on secondary and tertiary care	More than equal emphasis on primary care
Managed vertical programmes	Based on horizontal village and district level plans.
Target-driven	Flexible and need-based
Not geared to make linkage between poverty and ill-health	Based on structural understanding of poverty issues
No recognition of gender and equity issues	Recognizes gender and health linkages
Access and control with health bureaucracy. Minimal scope for peoples participation	Access and control increasingly with people who need these services the most

This led to the emergence of a 15-point health sector reform agenda which addresses the demand, supply, and administrative issues for the state, on which there would be a wide ranging state and civil society partnership. The state government recognized the importance of active civil society partnership. The programme being large and new, and the existing resources of the government being limited, such a civil society role was essential.

Also on the basis of this, a State Advisory Committee of civil society organisations was set up. To provide technical support for design and operationalisation of these initiatives on a full time basis, the State Health Resource Centre (SHRC), was set up. The SHRC is an autonomous institution with a governing body largely drawn from reputed health based non governmental agencies. The SHRC had an MOU with the government of Chhattisgarh which provided for its core support and defined its work areas. In the first two years ActionAid acted as a “host organisation” assisting in putting together a team and then it withdrew leaving behind a registered society with its own governance structure and well established operational manuals and guidelines in place.

III. Design / Features of the Mitadin Programme

Seven Cardinal Principles:

Learning from the past programmes, the Mitanin Programme adopted seven cardinal principles which are seen as critical to the success of the programme.

- I. Women as Community health workers.
- II. Well-planned social mobilization and selection process to ensure selection by the community. Selection at the hamlet/habitation level
- III. Training/support to be a continuous activity for the duration of the programme- not a one time initiating event.
- IV. No financial payments at least in the first year and later limited incentives, while retaining the mobilization and community based character of the programme
- V. Supplementary and not central role for curative care,
- VI. Linkage to a parallel public health strengthening initiatives.
- VII. State civil society partnership at all levels of programme management

Broad Objectives of the Mitanin Programme

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

Three Mobilisational Themes:

The success of the Mitanin Programme relates to a large extent due to it being a process of social mobilization built around two themes:

- a) "Hamaar Swasth Hamaar Adhikaar.": Health Care Services is our Right:
- b) "Hamaar Swasth Hamaar Haath."Our Health in Our Hands:

These themes were spread through song and dramas, in the form of kalajathas.

Phasing the Programme:

To cover the whole state required the programme needed to be phased.

The **first phase** of pilot phase began in May in 14 blocks of the state 2002.

The **second phase** of the programme

This began in December 2002. Half the remaining blocks, a total of 66, were brought into the programme.

The **third phase** of the programme:

This began in December 2003. All the remaining blocks were brought into the programme.

The **fourth phase** of the programme. This began in April 2005 in the first phase blocks and in April 2006 in all the blocks: All the blocks achieved their 20 days of 'induction' training and the continuation phase of training began. Programme design improvements, based on evaluation inputs, were put in place. Village level planning was institutionalized. In this phase there was a deepening of the Mitanin's clinical skills in child care based on the IMNCI approach, an introduction of AYUSH dimensions and a major thrust on malnutrition and food security.

IV. Key Programme Processes:

A. Selecting the Mitanin

Mitanin is selected by the community and this selection has to be approved by the panchayat (Local Self Government body). The community selects the Mitanin in hamlet level meetings held for this purpose.

The selection by the community has to be facilitated by a "prerak" (Motivator). The prerak ensures that the community understands the programme and makes an informed choice. The prerak has also to ensure that the voices of weaker sections within the community are heard.

The selection process was also supported by massive and rigorous social mobilisation activities centred around the Kalajathas, which is a cultural form that has evolved to promote social change conveying appropriate messages in the local idiom.

B. Training - The Centre of Action

The training of Mitanins involves 20 days of camp-based training and 30 days of on-the-job training and support. The training curriculum and strategy was devised to enable the Mitanin to fulfill her roles.

The camp-based training was achieved in seven rounds held at a suitable nearby training venue, usually in a nearby village *haat (market)* centre. This was supplemented by the on-the-job training provided in the village. The training syllabus was packaged into seven modules published as 12 manuals. The training rounds broadly comprised of:

- First round (4 days): Understanding Health/Health Services & Child Health and Nutrition.
- Second round (2 days) - repeat of the above as well as introduction of village health register for recording health service status and vital health events.
- Third Round (3 days) - Women's health
- Fourth Round (2 days) - Community control of Malaria and waterborne diseases
- Fifth round (4 days) - Mitanin drug kit and first contact curative care
- Sixth round (2 days) - Community role in TB and Leprosy control
- Seventh round (3 days) - Panchayat level health planning based on hamlet level health and human development index.
- Round 8 (2 days): Food & Social Security Entitlements
- Follow up: social mobilisation efforts to ensure community action for streamlining of food/social security schemes as well as to identify vulnerable families/individuals in the community.
- Round 9 (2 days): Home based herbal remedies
- Mitanins to understand the preparation and use of locally available herbal remedies.
- Round 10 (8 days): Neonatal and child Survival- based on IMNCI and Home Based care---Support on initiating home based care and prompt referral on neonatal/childhood diseases- aiming to impact IMR to the extent it is possible.
- Round 11 (2 days): Role of Mitanins in Village Health & Sanitation Committees- Special village general body meet followed by Village Health Planning based on HHDI(Health and Human Development Index)

- Round 12 (3 days): Addressing issues related to child feeding- to focus on the gaps identified by a special survey Follow up: joint action by Mitanins, ICDS programme and PRIs on feeding related issues.

Future Training_

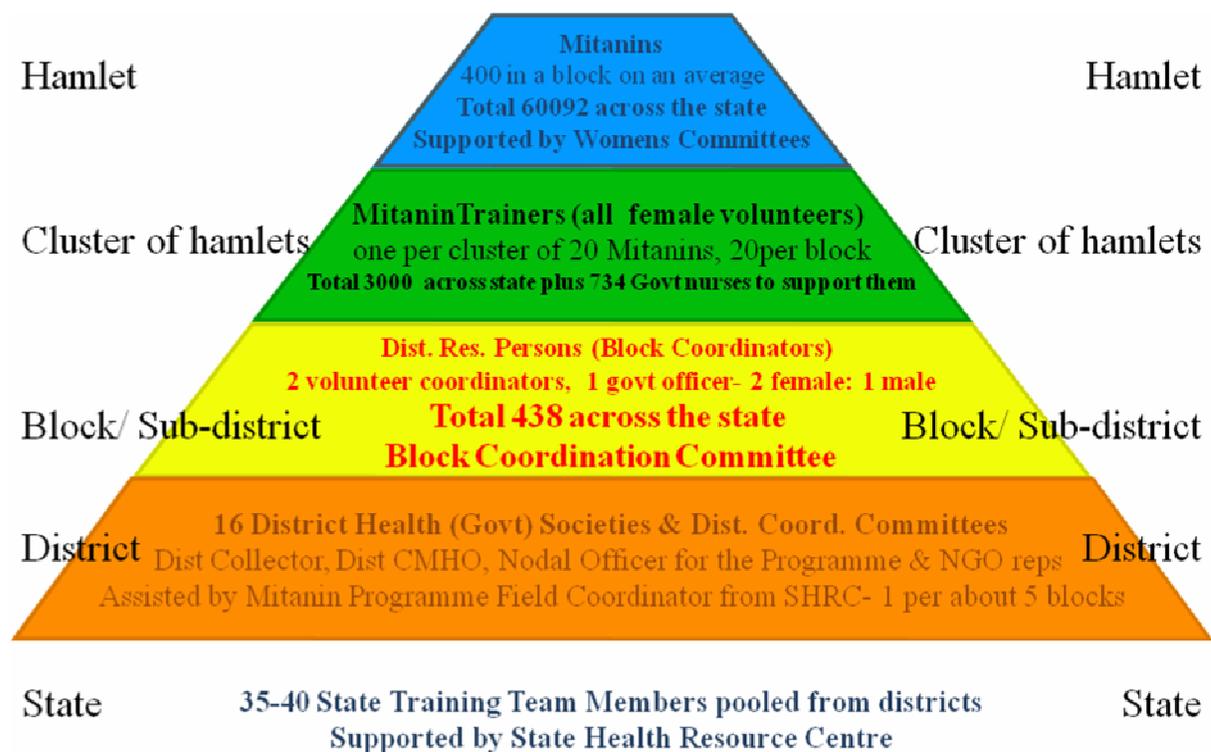
- Round 13(5 days): Introduction of a specially designed BCC tool kit, to address those critical behavior change areas which are still weak -Follow up: Campaign based interventions on key behavior areas, as identified in the behavior matrix.
- Round 14 (2 days): Re-orientation on National Health Programmes- RCH/family planning services, disease control programmes.

It was essential to supplement camp based training by on the job training. Where the latter did not happen the programme did not take off. On-the-job training helped to individualize training, refresh its content and convert training competencies into programme outcomes. On the job training required that trainers visit villages regularly and work with Mitanins there as well as hold local meetings of Mitanins and their health committees.

This in turn meant that every trainer had to be under contract to provide at least 20 days of training per month, irrespective of whether there was a training camp that month. Every block had about 15 to 20 such trainers and three master-trainers (or district resource persons as they were called). They were all appointed and supervised by the block project team.

The meeting of trainers held twice monthly was the site where the state training team, made of field coordinators could directly interact, guide and train these training teams- other than in the training camps. These field coordinators were employed and supervised directly by the State Health Resource Center, so as to ensure a good quality and stable full time state level training structure.

Peculiar Human Cascade involved in Mitanin Programme-



The Training Materials:

Ten training guides were published by dedicated resources, SHRC. These were meant to act as trainer's guides and as reading and reference material for Mitanins.

1. *Janta Ka Swasthya Janta Ke Haath* - Peoples Health in People's Hands
2. *Hamara Hak, Hamari Hakikat* - Our Rights and Our Current Situation
3. *Bacchon ke Swasthya*: Child Health
4. *Mitanin 'Tor Mor Goth'* on Women's Health:
5. *Chalbo Mitanin Sang* - 1-Guidebook on Control of Malaria and Waterborne Disease:
6. *Chalbo Mitanin Sang* - 2 - Guidebook on Mitanin Action on Tuberculosis and Leprosy Control.
7. *Kahat he Mitanin*- This is a brief pictorial summary of the key health messages of the first six books.
8. *Mitanin Ke Dawapeti* - The Mitanin's Drug Kit Guidebook: The management of common illnesses and symptomatic remedies using the 10 drugs in the Mitanins drug kit is covered.

9. ***Badbo Aage Mitanin Sang: The Panchayat Level Health Plan Guidebook***
10. ***Jug-Jug Jiyein Nanheman - (IMNCI tool for Mitanins)***
11. ***Jurmil Banabo Swasth Gaon- Guideline for village/local level health planning***
12. ***Naneman ka Palan Poshan Aur Paramarsh- Infant Young Child Feeding(IYCF)***
13. ***BCC tool kit-***
14. ***Malaria and Leprosy***
15. ***HIV/TB***

Apart from this, a village level health status and services monitoring tool called ***Gram Swasthya Register and the Mitanins Diary as a record of her work was*** also published.

The programme also published a “prerak guide” to guide selection and a ‘trainer’s guide’ to guide training. The trainer’s guide explained how each session was to be conducted and elaborated the whole training strategy. These books were critical for both trainers and for programme organizers though not essential for Mitanins.

C. Social Mobilisation and Mass Communication:

The Mitanin Programme focuses on the need for community mobilization as a crucial tool for participation by the local community and that too voluntarily. This was also needed to create an enabling environment for the inter-personal communication on health conducted by the Mitanin.

A popular 14 part radio serial with the Mitanin as the central protagonist was beamed at peak hours from all five radio stations in the state, twice. The programmes were made in Chhattisgarhi initially and later in the tribal dialect of Gondi as well. Women’s groups were encouraged to organize group listening to the programme and to send feed-back.

Two cassettes of specially written and recorded songs also captured the central themes of the messages and were used with all forms of mass communication and were sung in most meetings. These not only conveyed the spirit of the programme but also built up a sense of mutual solidarity in the participants.

D. Monitoring and Support: Managing the Programme:

At the state level the programme is conducted and owned by the directorate of health services.

State level training and Materials development and monitoring the programme is done by the State Health Resource Center, a state civil society partnership institution that has been specifically created to support the programme.

At the district level the programme is conducted by the district health societies. The district health society appoints a nodal officer for this purpose. The district nodal officer also coordinates the district Mitandin coordination committee and the full time district training teams which conduct the programme on a day to day basis. NGOs are represented in both these district structures.

At the block level the programme is conducted by the block medical officer or by a NGO. The block is the basic unit of programme administration on the basis of which grants are made, and progress is monitored. The three district training team members from each block (also known as the district resource persons- DRPs- play the role of block coordinators. The team of 15 to 20 trainers forms the block training team which manages the programme on a daily basis. An intersectoral block coordination committee was also attempted but with limited success.

At the village level the gram panchayat which endorsed the Mitandin selection and the ANM (Auxiliary Nurse Midwife) and anganwadi worker (Child Nutrition and development worker) support the programme. Women's health committees and self help groups, many of which are coordinated by the Mitandin also play a vital role in supporting her and making this into a community based effort.

At the village level the Mitandin diary and the Mitandin register helps the Mitandin in doing her work. At the cluster meeting the trainers use these tools as well as their interaction with Mitandins to monitor the progress and support the Mitandin. At the block level the field coordinators of the SHRC assist the block coordinators and the nodal officer in reviewing the reports from the trainers, using this to monitor the programme and also to train the trainers. There are special indicators developed to monitor the programme both during its early phase and to monitor outcomes in its continuation phase.

Conclusion-

What sets the Mitandin Programme apart from many other large scale programmes in the state is the stress it lays on continuous training and support through developing middle level programme management teams. The strategy of developing a middle level management is a

central challenge of scaling up programmes and the Mitanin programme was seized of this challenge. Such a programme also needs a dedicated and motivated leadership with the skills to negotiate to keep open a partnership space that bridges the traditional gaps between government and civil society and between traditional authority based programme implementation and more community based participatory processes. Which in turn requires a different work culture- more collective, more democratic, more equity sensitive- which bases its organisational strategy on regular contact and support of its workforce. The interactions mainly involve meeting with middle level workers regularly and they meeting with Mitanin regularly, and each troubleshooting problems of the next level, and constantly updating their knowledge. This also includes keeping their motivation alive and constantly renewing the spirit of a movement where the poor are not passive beneficiaries but increasingly active participants in change.

VI: Outcome and Benefits of the Programme

What were the expected outcomes of the Mitanin Programme?

- a. That there would be a trained Mitanin in every village.
- b. **That the Mitanin would be able to impart effectively key messages on health leading to improved health awareness and better health related practices like breast feeding practices.**
- c. That there would be a better utilization of health services.
- d. That the Mitanin would be equipped with the skills and the drugs to attend to common ailments.
- e. That the Mitanin programme would have the character of a campaign for women's empowerment and a women's movement for change.
- f. That the Mitanin programme would have catalysed village health planning and improved the capacities and motivation of panchayats to work for better health.
- g. **That the impact of all these above should reflect on key indicators of health care especially on infant mortality rates.**
- h. That the public health systems are expanded and are strengthened and have improved in responsiveness.

Programme Outcomes:

Facts and Figures- Mitanin Programme Indicators:

As per the latest report, the facts and figures of the Mitanin Programme stand as follows:

- Today more than 60000 Mitanins have been selected, 57,489 completed 10 rounds of training. The number of functional Mitanins today is 59,849. All the Mitanins have been supplied by a drug kit and there is a scheme to refill this drug kit on a regular basis. At the outset the programme provided for more than 54,000 hamlets. This has been achieved.
- 43987 Mitanins (73.3%) are visiting the family with a newborn on the first day and successfully counseling on six key issues of essential newborn and mother care
- 45178 Mitanins (75.4%) visit the families with pregnant women in the last trimester, ensure Ante natal care was accessed and help the family plan for a safe and where possible institutional delivery.
- 43390 Mitanins (91.7%) report being regularly approached by families in the village for first contact care with focus on diarrhea, acute respiratory infections and fever. Many of the children get life saving referrals to functional public health facilities in the vicinity.
- 45582 Mitanins (83.4%) regularly attend monthly immunization camps held in the local anganwadi and observed as the local child health and nutrition day. (Shishu Swasthya Poshan Mela). This is also an indicator of coordination of Mitanins with ANMs and anganwadi services and it indirectly indicates their activity in relation to improving delivery of these basic services.
- 37017(77.5%) are aware about the malnourished children of their areas and they do counseling of mothers on improving the status of these children.
- 36278(66.2%) are regularly holding women's health group meetings in the hamlet. This is a process indicator of women's organization as much as of health education.
- In over 5978 gram panchayats out of 9800 gram panchayats (61%) Mitanins working with local teams have measured achievement based on indicators and are in the process of making health plans.

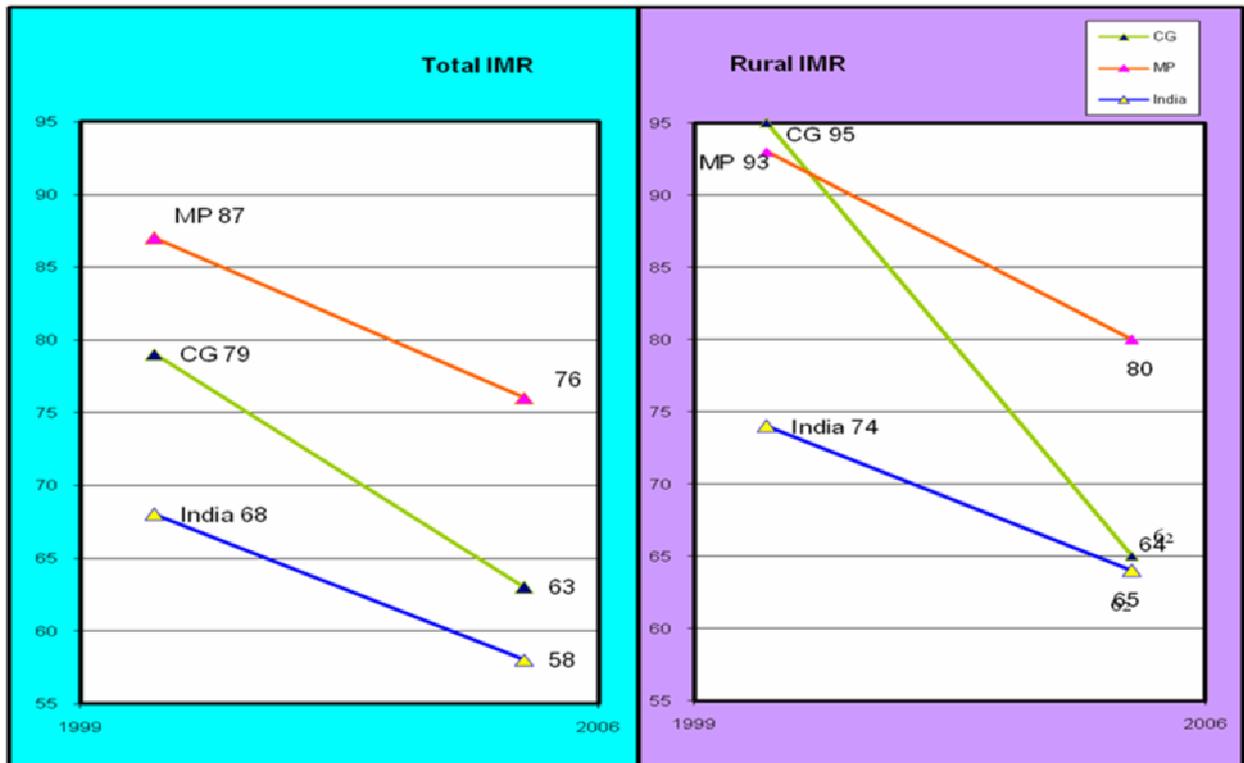
Facts and Figures: Health Outcome Indicators:

It is difficult to attribute any change in health statistics only to a single programme for most of them are multi-factorial. However by comparing it to the all India figures and to adjoining mother state of Madhya Pradesh figures where many socio economic indicators are similar we can search for the "programme effect".

Also we must remember that any achievement in service delivery is always primarily the credit of the ANM (Auxiliary Nurse Midwife) and the anganwadi worker without whose service, Mitantin driven demand alone could not have given results.

The graph below shows the change in total IMR and rural IMR from the creation of the new state till now based on SRS data. (Year 2000 and 2006 of SRS data are shown).

Indicators	India			Chhattisgarh		
	2000	2006	2008	2000	2006	2008
*IMR Total	68	58	55	79	63	59
*IMR Rural	74	64	61	95	65	61
*IMR Urban	44	40	37	49	52	49



Thus Chhattisgarh has seen a drop of rural IMR by 24 points in the two Mitantin years; as compared to a 5 point drop all India and a 6 point drop in Madhya Pradesh.

Since we also have figures for 2006 from UNICEF coverage evaluation survey and the NFHS- 3 survey we can try co-relating this IMR with other changes in health services utilization and health care practices.

Breastfeeding and IMR:

The single biggest possible contributor is the change in breastfeeding practices. UNICEF's coverage evaluation survey shows an increase in breastfeeding in the first day from 27% in the year 2002 to 88% in the year 2006- clearly a Mitani effect as the programme has been maximally focused on this intervention and as this is a very well monitored component of the programme. A landmark review in Lancet the première medical journal estimates that correct breastfeeding alone can contribute to a 13% decline in infant mortality and correct complementary feeding can save another 6%- far more than any other medical intervention. (Source: Jones et al. Lancet 2003;362:65-71)

"Exclusive breastfeeding for 5 months" is currently reported to be 82.0% according to the NFHS-3 survey, up from 35.1% in the DLHS survey of 2002-04. (Both survey use same methods and are done by same agency – the IIPS.)

Progress in other RCH areas:

Another major contributor to saving lives, measles immunisation, has gone up from 40% in the year 1999 (NFHS-2) to 62.5% now (NFHS-3). Total immunisation has however gone up only to 21.8% to 57. 58% (NFHS – 2 & 3 respectively) which though a big increase got pulled down due to problems related to one antigen.

The percentage of women who receive any antenatal care has increased from 57% in year 1999(NFHS-2) to 89% in the year 2005.(NFHS-3 surveys). However, due to service supply side constraints, that the state is working on but would take more years to overcome, increase in institutional delivery remains modest – from 14% to 16% only.

These figures however testify to an improved community level utilization of health services – one of the objectives of the programme.

Health Seeking Behaviour:

Other than these above factors we also feel that changes in health seeking behaviour have contributed significantly to these improved outcomes. Tribal and rural society had come to accept high neonatal and infant mortality as normal. There is a local tribal saying- a tree has

many flowers but few fruits. Once a child is born – till the sixth day it is not given a name, nor is its birth announced publicly, nor even shown to all family members. Only if it survives – such is the experience of neonatal mortality. But with the Mitanin programme this is changing. Now there is a growing insistence that every single child death is unacceptable and it is preventable. This is as much an effect of social mobilization as it is of the Mitanins' family level counseling. Mitanin's visit to families on the day of delivery, third day and another visit before tenth day is making a difference in New Born Care.

Disease Control:

The Mitanins have also made significant contributions to the reduction of malaria. In all hamlets Mitanins act as drug depots providing chloroquine tablets for suspected malaria and taking blood smears for examination. They take part in door to door fever surveys. They promote a better understanding of the disease and its control. Similarly Mitanins are also contributing to anti tuberculosis and anti leprosy campaigns, mainly facilitating case detection and compliance to treatment.

Strengthening Public Health System:

Mitanin referrals and mediatory interaction at primary health centers and community health centers have increased their performance and responsiveness- though there is still considerable way to go in this direction. To further it in many facilities the Mitanin trainers take turn to manage Mitanin referral desks that ensure that referrals are properly attended to. The Janini Suraksha Yojana (Maternity Benefit Scheme under National Rural Health Mission) has also helped.

The government of Chhattisgarh also understands that further reductions of infant mortality, especially neonatal mortality would require improved institutional care for sick children as well as Mitanins skilled to even higher levels. It would also require improved emergency referral transport systems, and better emergency obstetric care. The government is carrying out a rapid expansion and strengthening of health services to meet these challenges. But despite such an increase in sanction of facilities manpower and budget it would take more time before these translate into more services that people are accessing. But for now, with the Mitanin programme, it has made a good start. And as they say – well begun is half done.

Changes beyond the Health Sector:

Empowerment of Women

Empowering women is imperative if developmental objectives of any programme are to be achieved. Through the Mitanin Programme, the state enhanced the status of women by improving their access to and control over resources. It also increased substantially their role in decision-making. Crucial efforts were made to reduce the gender barriers in access to health care by making services more responsive to women's special needs. It also ensured accountability and promoted technology and skills that made services women-friendly and enhanced the availability of women health care providers.

It is difficult to quantify the empowerment of women, let alone the contribution of the Mitanin programme to this process. We note that there are widespread reports that the launch of this programme led to women undertaking a number of social activities in their own hamlets. One reflection of this is the performance of women and that too of Mitanins in the panchayat elections held in January 2005. Over 3000 Mitanins were elected to office. Many contested unsuccessfully. Many more raised issues pertaining to basic entitlements in the elections. One outstanding example is from Gram Panchayat of Bhelwadih, all members elected were women and the panchayat is declared as ideal female Gram Panchayat. Another is Pharsabaha block of Jashpur district where in the last panchayat elections 23 Panch, 5 Sarpanch and 2 Janpad members were Mitanins. Participation of women in gram sabha meetings is also improving.

Hence we would say with special strategic and dedicated effort on community based programme can lead to reduction of infant mortality and improvement in key health indicators.

***** Reference and write up from, "SHRC" A TEAM and Giving Public Health a Chance, Published by DOHFW, CG.***