WOMEN'S HEALTH TRAINING PROGRAMME

(A WHO assisted programme of the Ministry of Health and Family welfare)

AN ASSESSMENT OF THE PROGRAMME IN KARNATAKA

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by

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WOMEN'S HEALTH TRAINING PROGRAMME: AN ASSESSMENT OF THE PROGRAMME IN KARNATAKA[1]

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Introduction

The Women's Health Training programme of the Ministry of Health and Family Welfare sponsored by WHO is an effort to empower rural poor women to address the broader issues of health and to encourage informed health seeking behaviour and better access to health care facilities. The strategy developed was to train two women as health activists at the village level who would then catalyse other women to organise around issues of health, leading to some action at personal and community levels This was to be achieved through a cascade model of training

Assessments of the implementation of the training programme has been undertaken to get a clearer idea of the processes followed and the women's perception of the training as this would provide some directions for further consolidation and future course of action.

This assessment has been undertaken in the State of Karnataka. The effort in this process has been to gain a direct feedback through interactions with trainers, participating NGOs and finally with the women themselves at the village level. Some reports have also been perused. Field visits were made to Mahila Samakhya project area in Bellary and to field areas of Belaku and Sandeep Seva Nilaya in Bangalore rural area.

Evaluation schedule

23.2.01 Preliminary meeting with Dr.Thelma Narayan, Director,CHC and Dr.Revathy Narayanan and Amrutha, Mahila Samakhya at Bangalore

24.2.01 Field visit to Bellary

- Interaction with Father Pinto, Director, Bellary Diocese Development Society
- Field visit to Mahila Samakhya Bellary project area-

1. Cluster meeting at Ujjaini, Kudligi Taluka
2. Visit to Hunsikatte village, Kudligi Taluka

[1] I would like to thank CHC, Mahila Samakhya, Sandeep Seva Nilaya, Belaku being warm and open in sharing their opinions/ information and especially the women in the project areas in Bellary and Bangalore rural who have been a source of tremendous inspiration to me at a personal level. A special thanks to CHC for facilitating the assessment.

25.2.01 Field visit to MS Bellary project area-
1. Cluster meeting at Yellapuram

26.2.01 Discussion with trainers ate Bangalore
Observation of 1st level training of 2nd Phase of the programme
Perusal of documents

27.2.01 Field visit to Belaku project, Kanakpura, Bangalore rural area-
1. Interaction with Padmakka at Halsar village
2. Interaction with SHG group at Kadahalli village

28.2.01 Field visit to Sandeep Seva Nilaya, Nelamangala, Bangalore rural area-
1. Interaction with SHG group at Banaswadi village
2. Interaction with SHG at Jakkasandra village

THE PROGRAMME IN KARNATAKA

The nodal agency for the programme in Karnataka is the Community Health Cell (CHC), an NGO working on issues of community and public health. CHC participated in the initial discussions when the project was being formulated at the Ministry level and also in the preparation of some parts of the manuals. Mahila Samakhya Karnataka had already been identified as one of the major partners in implementation of the programme. 10 NGOs including Mahila Samakhya were identified for implementing the programme in the districts of Bangalore Rural, Chamarajnagar, Bidar, Koppal and Bellary.

Brief Profile of Nodal NGO and partner NGOs visited

- Community Health Cell (CHC) is the lead NGO in Karnataka. CHC has been working primarily in the areas of Community and Public Health issues. CHC sees participation in this training programme as having given a fillip to their work on women's health and evolving a working relationship with government. This is the first time that CHC has worked in partnership with the government.
- **Sandeep Seva Nilaya was** set up in 1993 and has been working in the Nelamangala taluka, Bangalore rural area.. Staring with leprosy relief work, the organisation has moved onto Women's empowerment programmes of organising women's Self-Help Groups. As on date there are 78 SHGs with a membership of around 500 women. Participation in this programme has given a scope to widen their work in the area of health

- **The Belaku Trust** was set up in July 1995 with the aim of carrying out research and providing services in the field of health, as well as in related areas such as education, income generation, micro-credit and provision of amenities. The main focus of the organisation is poor and marginalized households, with an emphasis on women's and children's health. Belaku research projects and studies include impact of rural women's work on children's health and well being; the effects of health beliefs and practices on obstetric morbidity; impact of nutritional counseling on infant feeding practices and growth faltering. This training programme enabled Belaku to develop strategies for community outreach work

- **Mahila Samakhya,** Karnataka is part of the Mahila Samakhya programme of Department of Education, Ministry of Human Resource development. The basic strategy of the programme is to set in motion processes that would strengthen women's self esteem and confidence, enable women's learning and empowerment. The basic strategy to achieve this is to organise rural poor women into collectives or sanghas. MS Karnataka has been working on women's health issues with a primary focus on herbal medicine. The WHO training programme came at a critical juncture when MS was developing a broader holistic health strategy.

Feedback about the manuals collected by CHC from partner NGOs

- Manual was useful and easily understood
- Add more games, role plays, skits etc
- For improvement add topics on disability, mental health, issues of local health problems, post partum depression, women and alcoholism, breast cancer
- Make language more simple
- More information on women and empowerment. Add case studies
- More information on community organisation and communication skills would be useful
- Most information though known, training made it more systematic

The TRAINING PROGRAMME

As envisaged in the project the training was done at 3 levels:

- TOT at State level
- District level Training
- Village level training of women

TOT at State level

The stated objectives of the TOT were as follows:

1. To explicitly understand the differences in society and its effects on women's health in society
2. To understand clearly the implications of women's health and their empowerment
3. To enable trainers to transfer the knowledge on health, through training of women in groups
4. To develop skills of communication with women on issues related to improvement of health
5. To create awareness in women on their health status on an individual basis and to promote an atmosphere of group learning and sharing
6. To understand the need to train women and through them to reach other women in society to develop positive health
7. To learn and develop simple home remedies by women for the community and the family.
8. To understand various government schemes and services available in order to promote their accessibility to women
9. To understand and develop skills for formation of groups
10. To realise the influence of gender understanding on women's health situation.

Some key decisions were taken regarding the TOT. The approach was to take a constructive and non-confrontationist approach to health. An important dimension of the training was to view women as individuals and not merely as participants or as deliverers of a programme. The attempt was not only to give information but also to develop an awareness of the positive dimensions of health and to enable women to act on health related issues

In an effort to bring in a variety of perspectives and methodologies, trainers for the TOT were drawn from a number of organisations like CHC, Mahila Samakhya, Vimochana, IPP-VIII project, Institute of Social Studies Trust, Directorate of Health and Family Welfare Services, Food and Nutrition Department (List appended)

The TOT was done in 2 phases in October and November 1999. 27 participants representing 10 organisations had agreed to attend both phases of the TOT. Among these, there was only 1-government health personnel, an ANM from Kankapura who works in close coordination with Belaku, one of the participating NGOs. Out of the 27 expected participants, 23 attended the first and second phases of training.

During the training an assessment of the participants own understanding of health was done and an effort made to build on this knowledge. Both phases of training were designed to use participative methodolgies. Exercises on self-reflection, personal growth, spiritual reflection, games, role-plays, songs and cultural programmes enabled the participants in several ways. Yoga and exercises were included. For many the training provided an opportunity to strengthen their individual knowledge and understanding of health and women's empowerment, various schemes available, the social underpinnings of women's health and finally exploring strategies of taking this forward at the village level. At a personal level the TOT enabled the master trainers to become articulate, confident about talking and discussing sensitive issues of sexuality and STD/HIV related issues, and initiating processes at group formation at the village level.

Concurrent review of TOT

CHC had commissioned a concurrent review of the two phases of the TOT to gain an insight into identifying areas that needed to be strengthened. The concurrent review was done by Ms. Vinalini . A detailed report of the trainings has been prepared.

TRAINING OF DISTRICT LEVEL TRAINERS

Two of the three NGOs visited conducted training at the district level for all their staff. In the case of MS, all the field and office staff including the male staff of the Bellary district office was given an encapsulated insight into the whole training programme and its contents. Except in the case of Belaku, none of the other two managed to bring in any government personnel either as trainers or as participants at the district level training.

The number of district level trainers varies. In the case of MS one Resource person, one Junior Resource person and 2 sahayoginis plus the sahyoginis from whose cluster the women are trained formed the core team

In the village level trainings , however, some government personnel like the ANMs, local doctors from the area, CHC doctors were invited to handle some topics. It is not clear what orientation if any was given to these resource persons. Except for the CHC doctors who were part of the State level TOT, the others came in only at the field level.

TRAINING OF WOMEN AT VILLAGE LEVEL

Among the organisations visited, the number of women trained was as follows:

- Belaku-24

- Sandeep Seva Nilayam-24
- Mahila Samakhya, Bellary- 72

Selection process

1. Belaku identified women to be trained through the anganwadis with which they had already a linkage.
2. Sandeep Seva Nilayam selected women trainees from among its SHG members
3. The criteria used by MS was membership in the sangha and those who were traditional birth attendants and already undergone some training in herbal medicines. MS had already identified 2 women in each sangha to be health committee members as part of its efforts to make sanghas strong and sustainable. In MS the majority of women who attended the training were Dais

In the case of Belaku and Sandeep Seva Nilaya all the women attended the 7 day training given in 2 phases. In the case of Mahila Samakhya around 80% attended both phases of the training. In the training of village women the participatory method was faithfully adhered to. Some sample village level training schedules are appended in the annexures.

FEEDBACK FROM THE FIELD

Given below is a summary of the feedback received in interactions at the field level from all the three organisations visited. The reactions are listed randomly and not in any order of priority.

Overall Perception of training	• Very useful and increased individual's understanding on health issues • Better understanding of superstitions • Clear understanding of impact of nutrition on women's health • Made them more articulate and confident
Changes in personal lives	• Now eat when hungry and do not wait for the men • Gained the strength to bring about change • Gained the confidence to talk to others on health matters and alcoholism • Being in a sangha has helped • Several women reported that they now ensure that every meal includes some vegetable or other esp.greeens

	• Feel they can influence decisions on girls marriage • Gained the courage to be mobile
Community level action	• Given applications to the panchayat for cleaning drains in the village and the area around the drinking water areas • Applications given for construction of toilets • In Jagatgiri village, Kudligi taluka, the sangha stopped the village community from using the school compound for toilet purposes • Ill effects of child marriage being discussed. In Rampur village, Bellary 7 sangha women stopped the marriage of a 12 year old girl
Ante/post natal care	The Dais who came for the training especially in the Mahila Samakhya project area reported the following • In the H.Veerapura cluster the Dais with the help of the sahayogini has started maintaining a record of pregnant women, births, herbal medicines used and a list of women undergoing family planning operations • Clearer understanding of the need for hygienic conditions and sterilisation • Advising pregnant women to eat better food and also the eating of papaya • Few days before the due date, dais advising the woman and her family to clean the place where the delivery is to take place • Encouraging breast feeding within half an hour of birth.(earlier this would start 3 days after birth

	• After delivery vegetables and more water being given. Earlier only limited water used to be given in the belief that the stomach would get distended The Dais were all very happy with the use of plastic models used to explain the female anatomy. (the model costs around Rs.100). They felt that it enabled them to have a clearer understanding of the whole menstrual and conception process. They suggested that every village group be given one such model that they could use in discussing these issues with other women and adolescents.
Sterilisation	• The discussion on HIV has increased awareness on sterilisation of needles. Sterilisation of needles is widely reported. Ensuring that ANMs sterilise and taking their own disposable needles to hospitals
HIV/AIDS	• Women are clear about the causes for HIV. While they are not fully cognisant about the magnitude of the problem, thy are aware that it is a killer disease. The field interactions in Bellary highlighted the high incidence. In the two cluster meetings at Ujjaini and Yellapuram, women reported 3 cases in Rampur, 1 in Hunsikatte, 2 in Veerapura, 3 in Yellapuram and 2 in Kalakamba villages. Most have died (men and women) and a few of the women are in various stages of AIDs having contracted the virus from their husbands • During the field visit, discussions were held with the Yellapuram sangha women on why it was necessary for the whole community to be made aware of this dreaded disease. The sangha decided to

	approach the panchayat and with the help of MS hold a village level meeting on HIV/AIDS and ensure that the young people of the village attend
Nutrition	• Women reported that in sangha meetings they keep a check on whether women are eating whatever vegetables are in season. Mudamma of Yellapuram never used to eat vegetables. She now does after the discussions on nutrition
Exercise	• This had a good impact. Several reported that whenever the group meets the do some stretching and dhyana exercises. A few women in Ujjaini cluster Bellary reported that they do 15 mins of exercise every day. • All the women were quite eager and curious about the impact of exercise on their health For most, however, the lack of privacy was a deterrent. Some reported that the men laughed and heckled them
White discharge	• All the women met during the field visits felt that the discussions on white discharge were most useful since this is a common problem. They claim to have a clearer understanding of identifying the symptoms for which medical help should be sought
Personal hygiene	• Sangha women reported that they all now wash the menstrual cloth and bathe regularly during menstruation. Earlier they did not change the sari for three days. They are also advising the young women in their families
Other outcomes	Trained women enable women's groups to be formed in some cases. • Women from Nagenhalli village in Kudligi

	taluka, Bellary reported that their discussions on health while at work in the field evoked the interest of women working in the neighbouring village fields. Nagenhalli sangha was invited to Beladavi and Benekanhalli villages and they formed sanghas of 22 and 9 women respectively around the issues of health • Venkatamma of Buhalli village started a SHG of 10 women after the training in her village • In Kadanhalli village after the training an SHG of 9 young women was started. They were given training in making handmade paper and are running a successful unit. • MS sanghas have reported that the number of women coming to sangha meetings has gone up with the increase in discussions on health
Sharing mechanisms	All the groups and women met reported that after the two phases of training, information was shared with other women and sangha members if there was one. The Mahila Samakhya groups have all been given a copy of the village level modules and some other material as well. In some cases the health agenda is kept alive through discussion and reading of material given • In Rampur village, Bellary, a girl who has studied upto BA reads out part of the manual periodically to the sangha women. Other sanghas follow a similar pattern • Ensured that young girls in the family maintain personal hygiene during menstruation • Discussed with other women how to deal with problems like white discharge and

	when to seek medical help • Encouraging all in the group to eat seasonal vegetables and to eat a full share of food • Some women have taught others exercises to reduce back pains
Gender discrimination and violence against women	Not many women remembered specifically much on the discussions on gender discrimination. Generally they felt that girls and boys should be treated alike. And given equal share of food • In Kadanhalli village, Rukmini and Nagamani, two young women who had attended the trainings talked about gender bias in society, an important aspect they recalled of the training. They talked at length of alcoholism and the consequent violence that women face in the household. They also talked of mental stress and tension that women experience. The hand paper making unit of which they are members they felt provided them some respite from tension and gave solace since they are able to draw support from others in the group. When one of their members faced some problems with her husband the group intervened and counseled both the husband and wife. The main concern is what to do about alcoholism. Belaku the organisation working with them is also exploring strategies to enable the women to cope and address the issues of alcoholism and violence
Herbal medicine	All the NGOs had incorporated a component on herbal medicine. This is an area of great interest. Sandeep Seva Nilaya had added a component

	on herbal medicine in their training • In Jakkasandra village, Nelemangala taluk, the SHG of 17 women prepares balms for headaches, cracked feet, pimples etc. several of the members are young women and are enthusiastic about the balms for cracked feet and pimples.
Reactions of the community	• Some of the older women not convinced of the new practices being promoted like drinking water, eating vegetables, breast feeding immediately after delivery • Positive response from women especially of the sangha/SHG • The larger community/panchayat is either unaware of the training women have undergone or are lukewarm in their reactions
Needs identified by the women	• Periodic training both as a refresher as well as to consolidate what they have learnt • more information on anatomy • Infertility and what causes it. What can be done • More information on HIV/AIDS and what can be done • Some more pictorial material • How to work with the panchayat

Case study I:

From Learning to Action
Hunsikatte village, Kudligi taluka, Bellary

Mahila Samakhya has been working in Hunsikatte village for the past three years. A small sangha of 12 women has been formed in this village. As in other villages the sangha has a health committee of 2 women. Rachamma, health committee member and a dai herself attended the two phases of training organised by Mahila Samakhya. The membership in the sangha had dropped after a sangha member lost in the panchayat elections.

Rachamma is a wiry, energetic woman with a sharp memory and tremendous confidence. In the field interactions she was one of the few who could vividly recall almost all that had been discussed in the trainings. Her sangha did not, however, remember all she told them. Some things were remembered were the ill effects of alcohol, the need for better nutrition and clean surroundings.

After the trainings, the sangha was very proud of the work they had done under the leadership of Rachamma and Iramma, a devadasi also a sangha member A word about Iramma would not be out of place. After having participated in the national level Sanghamitra workshop organised by Mahila Samakhya at Delhi, Iramma came determined to change her life. Her first act was to cut off the long tresses a characteristic symbol of a devadasi. She gives strong vocal and physical support to Rachamma and the sangha.

After the trainings, the sangha reported that they had mobilised men of their homes to stop arrack jeeps from plying in the village. They have managed to do this for the past 6 months. Iramma who is functionally literate has written down the name of all those who helped in stopping the jeep.

In February of this year, all the sangha women got together and first cleared all the rubble, trash around the anganwadi. As they said " children's health is important". They then cleaned all the drains of the village, cleaning them and ensuring that there is a free flow of water. The areas around the three drinking water handpumps were also cleaned. They negotiated with the panchayat to lay stones in front of houses where there was usually waterlogging. They have many plans for the future- getting toilets constructed, housing sanctioned, a dhobi ghat built to prevent drinking water areas getting polluted and starting a collective economic activity by setting up a masala grinding unit.
Discussions with the village youth and others in the village on the day of the field visit elicited their perceptions. Every one felt that the sangha was working for the common good health of the village. When asked why they did not participate in the cleaning activities, everyone said they were not invited. The sangha responded that it did not occur to them. This perhaps is indicative of the need for enabling the women's sanghas to reach out and bring in the participation of the village community especially in activities that affect all people in the village.

Case study II

Changes in a woman's life: the case of Padmakka of Halsur village, Kanakapura Taluka, Bangalore Rural

Padmakka , one of the women trained by Belaku, is a middle aged Dalit of Halsur village. Married with 4 children, Padma works in her own fields. Having studies upto class 2, she has some basic knowledge of numeracy and can read and write a little.

Ms. Jayanthy, the local ANM who is in close touch with Belaku, the NGO, told Padma about the training and brought her to the training programme. Padma attended the 7 day training given in 2 phases by Belaku.

After the training, she began to talk to some of her friends and neighbours on health issues. Alcoholism is a major problem in the village. Padma is now confident enough to talk to men of the village as well. She says she does not preach that they stop drinking but tries to convince them to provide for the family. At a personal level she supports and counsels whose husbands drink. She advises people to take their own disposable needles when they go to the doctor to avoid infections of all kinds.

As earlier indicated, the biggest change post training was on Padma herself. She became articulate and keen to play a leadership role. She was enthused to learn tailoring through a government training programme for SC/STs. A member of the Weaver's Association at Satnur, she took the decision to stand for the Presidentship of the Association. Belaku gave moral support and encouraged her to realise her ambition. Padma is now President of the Satnur Weavers Association, which has a membership of 300.

Padma is now trying to revive an old sangha in her village around an economic activity. She sees this as the fora where the health issues could be further discussed and some action planned.

ASSESSMENT OF THE IMPACT OF THE PROGRAMME

The brief field interactions at the field level and with key trainers and organisational heads indicate that this programme has had a positive impact at different levels- at organisational, individual and collective levels.

- Generally the partnership between a nodal agency and other NGOs has been seen in a positive light. All the partners felt that they have been allowed to retain their individual flavour in the implementation of the programme. By and large the management and coordination of the programme has been smooth except in the case of Bellary, where the programme was to be implemented by Mahila Samakhya and the Bellary Diocese Development Society, each having to train 72 women. The coordination and communication between MS and BDDS was problematic. Though BDDS had hosted the second phase of the TOT and generally been very supportive during the training, in the implementation of the programme several problems surfaced between MS and BDDS. A major problem seems to have been that money was routed through MS to BDDS and in this process differences on accounting, reporting and monitoring procedures cropped up leading to a total impasse. BDDS felt that they have a vast experience in the field of health and MS did not accord them due respect and recognition. Both MS and BDDS feel that they are not in the wrong. CHC interceded to resolve the problem but it remained unresolved.

- For all the participating organisations, this training programme has enabled a holistic understanding and consolidation of their work in the area of women's health.

- For CHC this has been the first experience of working with government. Further involvement in this programme has given sharper focus and push to CHC's work on women's health. The perspectives and experiences of this training programme has informed the formulation of the state level health policy through the participation of CHC in the Taskforce set up to draft the State health policy. Belaku and Mahila Samakhya have also participated in the discussions preparatory to the formulation of the policy

- In the case of Belaku that has so far been essentially a research organisation it provided an opportunity to develop a community out reach strategy and to initiate processes for group formation.

- Sandeep Seva Nilaya that had already begun initiatives to work with women, this programme enabled a strengthening of the health component that had so far been confined to health messages and some awareness work. The beginning made is being carried forward through monthly interactions with SHG leaders and members on health

- For Mahla Samakhya, this programme came at an opportune time when the organisation was trying to evolve a broad health strategy and trying to move away from a primary focus on herbal medicine. Though the programme was limited to training of only 144 women in Bidar, Kopal and Bellary, the participating NGOs have extended the training package and the

experiences of the programme to other MS districts as well. This training has been given to health committee members of 40 sanghas in Raichur, 75 in Gulbarga, and to all the 186 sanghas in Bijapur. A one day health mela was organised in Mysore. A five day training was organised at the State level for the MS health committee members.

- All the trainers one interacted with felt that participation in this programme has made a tremendous difference to them personally. Not only only has it enhanced their knowledge on issues of women's health, but also enabled them to look at all aspects of health through a gender lens. Giving training to others has developed their confidence and communication skills

- At the village level, the women are very positive and feel that this training should be extended to many more women. Women recalled issues that they had experienced themselves or what had been introduced through an experiential method. The key seems to be to evoke a connection to one's life experience; or through demonstration—For e.g. Yoga/exercise through demonstration and an integral part of training; Nutrition through demonstration; RCH part of a woman's life experience—these are sharply etched in their memories and have been translated into some action at the individual and collective level. In the case of MS since sanghas are already engaged in collective action there is some effort at interacting with the wider community on health issues

ISSUES OF CONCERN AND SUGGESTIONS

- Profile of women to be trained needs some reconsideration especially in the case of MS where many of the dais are very old. It maybe useful to have younger women being trained along with the older dais. This would also ensure passing on of knowledge and the creation of a next generation of birth attendants.

- Recall of what has been learnt seems to be a general problem. Women remembered what was close to their life's experience. For instance all the dais were clear on RCH and ante/post natal care, an area they were primarily interested in. Younger women were more sharply aware of discrimination and gender disparities. It appears that too much has been packed into a 7 day training. In the process the general health issues have been given shortshrift in the training at the village level. Sustaining the learning process has been difficult. It would have been useful if some time had been allocated for refresher sessions in between to consolidate the learning or at least a system in place for the trained women in a district or even at state level to meet and share experiences.

- Given the problems with recall, transmission of learnings to other women in the village also is only partial. There are other problems with the manner of transmission as well. While the women were taken through a participatory and experiential mode of learning, they in turn are not capable of replicating this process at the village level. From their own feedback it is clear that the methodology of training has had a great impact on what they internalised. Quite clearly this area needs the sustained support and input from the concerned NGOs.

- Follow up has generally been weak and ad hoc. A record of how many women have actually attended all 7 days of the training is not available with all the organisations. It was not clear how the post training sharing at the village level was monitored. Since Mahila Samakhya has field level workers for every cluster of 10 villages, follow-up at the village level was possible. Some simple reporting formats (pictorial/visual) could be developed for the women to maintain a record of how they as individuals or as a collective are applying the knowledge gained. As indicated earlier in the MS areas the dais are maintaining record.

- Reaching out to women in the village and action at the community level is weak Community level action is dependent on the presence of strong local level groups. Not all the organisations have experience of mobilising and empowering groups. Some like MS have experience of organising strong women's sanghas. This is a component that needs greater attention. It must be remembered that forming an SHG in itself does not mean that a strong empowered group is formed. SHGs tend to confine themselves to economic activities. The organising NGO needs to provide sustained inputs on gender and social issues, if these are to function as gender sensitive and empowered groups capable of addressing gender issues

- Interaction with community and panchayat needs further visualisation to enable action. This is a problem not only for the women at the village level but also for some of the NGOs themselves. . Even where groups exist there is a need for enabling something like an action plan. The women are foxed after a point as to what and how to go about doing things

- There is an urgent need to add a component on adolescent girls health

- Linkages with government have not been established as anticipated. There is a need for a more concerted action at different levels. Even though the response at higher levels is positive and proactive, this has not trickled down to the district levels. The training teams did not include government personnel as originally envisaged. In some cases at district levels they came in as resource persons to talk about specific topics. There was no sustained involvement. In the second phase of the programme CHC has involved the Government

from the very beginning and got letters issued by the Secretary Health to all districts, in the hope that this would facilitate greater government involvement. This is a positive trend in that it establishes the government's commitments to the programme, something that was not as clearly established in the first training programme.

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