Jawra Devi Kasturi Devi Sugni Devi Teji Devi Noja Devi Shanti Devi Badu Devi Lakshmi Devi Sammu Devi Barju Devi Dhapu Devi Mukhi Devi Gawra Devi Pempa Devi Kasini Devi Khatu Devi Reshma Devi Hurma Devi Ganga Devi Lali Devi Parmi Devi Saraswati Devi Santosh Devi Chauthi Devi Jani Devi Nathi Devi Mohini Devi Kamla Devi Shayar Devi Soni Devi Sohan Kanwar Jamuna Devi Lakshmi Devi Gomti Devi Maghi Devi Rami Devi Manohari Devi Nainu Devi Chini Devi Kailashi Devi Khamma Devi Gowra Devi Phooli Devi Chunni Devi Pappu Devi Sua Devi Jamuna Devi Nasiba Moomal Nainu Devi Jamuna Devi Choti Devi Radha Devi Gawra Kanwar Paro Bai Dhapu Bai Babri Bai Lichma Bai Aasu Bai Bhuri Bai Gawara Bai Meera Devi Jeti Bai Shiv Bai, Badhu Bai, Samu devi

barefoot doctors

experiences from the Thar

URMUL TRUST

Knowledge Partner :
Desert Resource Centre

barefoot doctors

experiences from the Thar

Acknowledgements:
Pushpa Purohit, Gyanendra Srimali, Dr. Harishankar Bhojak, Ram Prasad Harsh, Himanshu, Arvind Ojha

Developed by
Deepika Nayyar, Ravi Mishra
Urmul Trust, Urmul Bhavan
Bikaner 334001, India
mail@urmul.org

Published by
Urmul Seemant Samiti
Bajju 334305, India
uurmulssb@gmail.com

Content

Acronyms used in the document

ANM: Auxilliary Nurse Midwife
ASHA: Accredited Social Health Activist
CAD: Command Area Development
CHW: Community Health Worker
ICDS: Integrated Child Development Services
PHC: Primary Health Centre
SHG: Self Help Group
SMC: School Management Committee
VHSC: Village Health and Sanitation Committee

Preface

900,000 newborns, in India, die every year. This means more than one child is dying every minute! Over 350,000 mothers die due to complications during pregnancy and childbirth. Nearly 115 million children, globally, remain undernourished and over 40 percent of these live in India. Pneumonia and diarrhoeal diseases are the biggest cause of death of children under age of five. Tuberculosis and Malaria are preventable, curable yet are the most fatal diseases. The coverage of crucial child-health services often remains inadequate and under-addressed.

The governments, world over, are making efforts to strengthen the core of the society – mother and child. India has an extensive health care system and infrastructure in National Rural Health Mission and other platforms. India, however, faces stiff issues in making an effective last mile reach. Attributing to systemic loopholes and the expanse of the country- this otherwise comprehensive system becomes handicapped. Moving towards the west end of the country-in desert Rajasthan, the challenges aggravate further because of the desert ecology and socio-economic demographics. The traditional and social milieu rooted in feudalism and patriarchy, additionally intertwines the system fallacies

Amidst these poor and classically unique situations of health care system and inefficient delivery, Community Health Workers have proven to be enormously effective in linking communities with health services. They are a local resource unit well-trained and most effective in formal health service delivery at the grassroots– both in costs and in resources. CHWs being the local individuals seamlessly integrate the first hand-curative medical service with locally contextualised awareness advice. They have proven to be highly effective advocates for social justice, gender equity, and education awareness.

Post the Alma Ata Conference in 1978, states world over have been experimenting with the concept of Community Health Workers. Since then, CHWs have become a phenomenon in the global south

or the marginalised regions all across to support primary health facilities. The African and the Asian experiences, over time, substantiate the relevance and need of the Community Health Workers. The developing countries, amidst their poor economies and limited resources, strive to improve health care infrastructure and allocate more efficient resources to better their healthcare services. Towards achieving this CHWs play a vital role in delivery at the grassroots and also in educating their communities to take the onus for better health.

This publication is an attempt to document the learning and experiences of Urmul- a network of NGOs working in over 1000 villages in Thar Desert of India- has been working with Community Health Workers for the last 25 years. It documents a localized and decentralized approach of the specific intervention- designed, executed, adapted and up-scaled starting with over 80 remotest villages in Rajasthan. We hope the document will be helpful for those working in similar domains, practitioners, academia, policy makers and community, at large.

INTRODUCTION

India is one of the fastest growing economies today. The large dividend, resting in the world's largest youth population, is providing the nation with the much-heightened acceleration. This has resulted in attention to improvement plans for healthcare systems in the recent years –in both, raising awareness and service delivery. Recognizing the importance of health in the process of economic and social development, the National Rural Health Mission (NRHM) has been set up to carry out necessary architectural corrections in healthcare systems. This aims to ensure the last mile reach and effective delivery. However like many other programmes, this is also designed in a centralised approach. Homogenous and largely sweeping solutions, designed in a 'common everywhere' design does not effectively address the root-cause, rather it ends up creating newer loopholes in execution and operations. With limited resources, poor support and inadequately trained leadership the system ends up on low delivery and unsustainable pathway.

The Thar Desert expands in 200,000 square kilometres and Bikaner district covers over 27,244 square kilometres. The climate and terrain makes it the most inhospitable and forbidding places in the country with temperatures reaching below freezing in winters and in excess of 48° C in summers. Rains are infrequent and do not exceed 27 centimetres. Depending on rain and yield season, families here live moving between the village and their Dhanis (hamlets). This makes even basic facilities in health education and governance difficult to, both, access and delivers. The public infrastructure remains very limited and mostly defunct. The distances between villages and Dhanis make availability of appropriate medical care a logistical difficulty, especially, in case of an emergency. Sometimes the average travel distance to access the most basic health service could be at a minimum distance of 50 kilometres. Reaching out to a specialised doctor might be over 150 kilometres travel, at times.

Over the last one decade this Desert has undergone paradigm shifts. The life and living in the desert is rapidly changing. Influx of money in local economy and influence of urbanisation are fast impacting and in many spheres affecting the traditional systems. The medical facilities have been improving and the communities are getting more aware and responsi-

ble on health, sanitation and institutional services for health care, especially for women and children. However, despite this institutional, economical and social change- inadequate access to healthcare, nutrition, sanitation, and early learning stimulation for children makes communities vulnerable. The social scenario adds to their already weak nutritional status especially of women. Gender discrimination, child marriage, large family size and low literacy continue to affect the marginalised in the community.

Appropriate medical facilities are only available at the block level while any specialised diagnosis and treatment can be made only at the district headquarter level. In spite of the implementation of National Rural Health Mission, the system continues to lack in its reach. The number of PHC and CHCs are limited and are spread so far apart that one covers an area of sometimes as large as 50-kilometre radius. Even at these health centres the number of the patients that can be catered to fall starkly short of the actual need.

On the other end, any private medical service is unavailable and if at all- it exists- it charges exorbitantly high. Infrastructural constraints are further intensified by lack of substantive knowledge, awareness and behavioural limitations about health. In these scenarios, to counterbalance the above-mentioned issues, the CHWs have been working in the desert relentlessly for the last twenty-five years. They have been providing basic healthcare and facilitating in-time referrals to the communities. They also play an important role as members of VHSC to ensure health care systems and hygiene in the villages. They also volunteer to bring a change in the spheres of education, childcare and early childhood development, livelihood and other development needs in the villages by sensitizing and information bridging. Their efforts and delivery makes them indispensible in the development of their villages and Dhanis. They have been working to organise community indigenously and to help create a sustainable development led by the community, which would drive improvements in Health, Livelihoods, Education, and most importantly create a space for mother and child care with special thrust on early childhood care and holistic development.

This, here, is a comprehensive study of twenty-five years of the CHWs' efforts and inputs and the impact of this in and on the communities. It is to congregate the qualitative insights of the Primary Health Care programme and to understand the interplay of the community health workers and the government functionaries as it stands today and to ascertain a possible roadmap for the future.

Who are Community Health Workers?

Community Health Workers (CHWs) are called by a variety of names including Health Auxiliaries, Barefoot Doctors, Health Agents, Health Promoters, Family Welfare Educators, Health Volunteers, Village Health Workers and Community Health Aides. Here, in the desert, they are locally called Swasthya Sathin or Swasthya karmi. In these frames or names their goal remains singularly in-focus - strive for a healthier community – not just confining to the physical beings but working for the bigger system, causes and effects and in short, the comprehensive well being of community. CHWs deliver preventative as well as basic curative medical services at the very roots of social systems.

They are extensively trained volunteer-workers, working from within the community they belong to. They perform variety of service delivery, motivational and educational roles in primary health care. They monitor the community's health, identify patients at particular risk, act as liaisons between the community and the health system and interpret the social climate. They are practical means of providing longevity and life to a health program. CHWs help health care systems overcome personnel and financial shortages by providing qualitatively trained, cost-effective services to community members in their homes, and by catching serious conditions at an early stage, before they become more dangerous and expensive to treat.

CHWs spend most of their time making household visits, responding to simple treatment needs, conducting group educational sessions, meeting with local leaders, community-based organisations, women and youth. They are, most often, the only available means to reach parents and children in their homes where the majority of common health problems originate and can be easily through simple practical measures be checked. Most common health problems are due to lack of hygiene and nutrition and to the lack of income and education, and largely, due to the weak status of women in the family and community. Many communities lack the access to basic drug supplies, a need to which CHWs most often respond.

CHWs help patients overcome obstacles to health care by accompanying patients through treatment, monitoring needs for food, housing, and safe water,

leading education campaigns and empowering community members to take charge of their own health. They organise the community for preventive and promotive activities necessary for primary health care. CHWs establish relationships of trust with their patients, bridging the gap between the clinic and the community.

Responding to needs of the village, they undertake provide the following responsibilities:

Δ First-aid & treatment for minor illnesses

Δ Check-up at the onset of pregnancy

Δ Giving pre-post & natal advice, also coordinating for safer institutional deliveries

Δ Encouraging institutional deliveries

Δ Advocating ICDS & AWC for early child care and development (ECCD)

Δ Nutrition: monitoring, delivering and educating

Δ Immunization: monitoring, dispensing and educating

Δ Family planning: services and advising

Δ Sanitation and hygiene: educating as well dispensing

Δ Communicable disease screening, monitoring, follow-up and medication provision

Δ Assisting in health centre activities

Δ Making emergency referrals

Δ Performing school health activities

Δ Collecting vital statistics

Δ Mobilization and financial empowerment of women, through Self-help groups

Δ Distributing medicines

Δ Participating in community meetings like those of Village Heath and Sanitation Committee (VHSC)

Community Health Workers and Urmul

For over two decades, Urmul has trained and supported community health workers, as a response to community needs for basic health services. Over 200 women have been trained and work relentlessly in Desert towards bettering of the health services in the villages and dhanis. These women have facilitated the organisation of the community, motivated participation and increased ownership and accountability of the people towards health care and availability of services. With this vision of organizing community, mobilizing collective action and developing skills for self-reliance, the programme was initiated with the training of traditional birth attendants as Swasthya Saathis or Community Health Workers. The first batch of CHWs were incubated and trained in 1986 to facilitate primary health care in the villages and the remote parts of the desert.

In those early years of the programme in 1980s and 90s, the formal healthcare system seldom reached the villages and was inexistent in remote parts of this desert. Understanding the need in the sphere of health, community health workers were identified as the best and inexpensive solution with high reach and accessibility within the communities. It was realised that it was exceptionally important to educate the community about health and health issues, remove the superstitions attached to it and then, address the problems of accessibilities of reach of the

formal, both public and private, medical systems. Urmul held its vision of 'leading the poor to self-reliance by making available to them various developmental services that they themselves decide on, design, implement and eventually finance'.

Objectives and Strategy

Urmul saw the role of providing primary health care (hereinafter PHC) service as an entry point through which various development services could be made. Initially, the objectives were established around the plan to provide basic health and education services, focussing on the reduction of maternal and infant mortality rates, increased access to health care facilities, detection of endemic diseases, like tuberculosis, and malaria, elimination of night blindness and anaemia. Community's participation and motivation was of utmost importance for a comprehensive socioeconomic development. The lack of income and education were major reasons behind the unacceptable state of Health. To address the issues in health it was necessary to simultaneously explore livelihood, encourage education, with a special emphasis to girls' education and improve the status of women in the family and community.

Gradually, a divergence in the strategy was needed. The thrust expanded from- health care, maternal and infant health, and ECCD- to increasing the linkages to health services through formation of women's groups, increasing accessibility to formal systems and diversifying the opportunities to livelihoods, directly as well as improving linkages to financial facilities.

The programme began with the support of Aga Khan foundation. Then, Government of Rajasthan supported 30 Swathya Saathi in the first phase of the programme through its fund for Border Area Development fund in 1988. Later the World Food Programme appreciated the efforts of the CHWs and they through CAD granted funds to replicate it in 150 villages in the canal area of Bikaner – Pugal, Khajuwala and Bajju. In 1996, the Government of Rajasthan piloted the Swasthya Karmi programme for two years. This was withdrawn due to lack of funds even though the programme was much appreciated for the impact it created in the villages. This, however, went on to influence the structuring, planning and strategizing the role of ASHA and NRHM. Plan International through extension sustained the efforts. Applauding the efforts, the team from Urmul was asked to advice and train Swasthya Karmis in Madhya Pradesh. The District Poverty Initiative Programme (DPIP) initiated a programme called Indira Gandhi Garibi Hatao Yojana in Chttar-

pur district. A team had also visited the area on an exposure visit for experience sharing.

Services, Delivery and Mechanisms

To carry out the laid objectives, Urmul devised a three-tier strategy.

Village Level: At the village level, the communities identified a local woman, often a Traditional Birth Attendant or a Dai, to be the Swasthya Sathis. The community suggested and selected the CHW. These women were trained to provide pre, post and natal care; conduct safe deliveries; provide information, educate and motivate for immunization, monitor growth, nutrition and family planning; treat minor ailments; identify cases for referrals. After the selection, each CHW was oriented and trained for three months- the first month they were trained theoretically at the Urmul Campuses. After the classroom training the women went back to villages for twenty days where they practiced their learning. After 10-day practical training the women returned to the campus. Here, they corresponded their field experiences with theory and further trained to fill any gaps that arose. These trainings were specially designed to help women learn and practice with ease, for e.g. symbols and pictures were extensively used as a mode of training to overcome the barrier of literacy. Each CHW was given a medicine kit with 'Safe Birthing Kit' and a baby weighing scale 'salter'. She, in the start, was paid an honorarium of 100 INR per month along with an incentive payment of INR 1 for each person registered and INR 100 for each delivery.

Organisation support: The second tier consisted of extension workers, professional staff who visited villages regularly. In addition to support and supervising the CHWs, these people provided a range of preventive, promotive and curative care. They also supported and motivated education and information on various themes in the community.

Professional support: The programme physician and cluster/field coordinators made up the third tier. The physician provided the basic medical care mainly at the Urmul-run hospital in Bajju. The physician along with the team made frequent visits to the villages addressing their medical problems and also making referrals at the hospital in Bikaner. They also organised and conducted various medical camps in close partnership with public healthcare system catering to different diseases at different times – from malaria to TB, to Eye care to ENT camps. Apart from the services in the field, the physician provided training to the CHWs and was a source of constant support to any need arising in the field area.

After the introduction of NRHM, the CHWs make referrals to the ANMs, the visiting doctors and also to the Government Hospital at Bikaner. . Health services include immunization, pre, intra and post natal care, growth monitoring, family planning, tuberculosis and malaria identification and treatment, distribution of vitamin, iron supplements to deal with anaemia. The programme had been and still continues to be integrated with other programmes undertaken at Urmul, to provide a holistic approach to the overall development of the community. It had initiated various income generation activities (wool spinning, weaving, crop loans, seed banks, embroidery, livestock distribution), education (non-formal education centres for children, six-month residential education bridge camps, Sarva Shiksha Abhiyaan and supporting Kasturba Gandhi Balika Vidhalaya), agriculture (water supply, rainwater harvesting, afforestation), and community organisations (women's groups, self-help groups, youth groups

and forums – Bal mandals and Kishori Prerna Manchs). All these are community led and based on participatory approach where Urmul primarily provides linkages to various existing facilities and motivates the community towards self-reliance and sustenance. Over the years, witnessing the changes in the public facilities, the influxes in the society – money and otherwise, and understanding the need for self-reliance in the community, Urmul has consciously withdrawn from providing direct services and shifting thrust in increasing the accessibility and linkages to the formal available facilities and systems. The shift has been towards a rights based approach rather than service delivery. Even in the primary health care programme, there continues the first and second tier of system, but the third tier has been willing dropped given the improved public facilities, its accessibility and the implementation of National Rural Health Mission.

Babri Bai, has worked as a Swasthya Sathi for years in her village- 2 AD. Remembering the time around 1996-97, when Balika Shivirs were being initiated, she narrates, "Girls' education was an absolute no-no. We did not even discuss this in our society and in this happened the Balika Shivirs. Who would send 12-15 year olds for six months to another place and that too for education in those times. One could not have imagined so. But I wanted to send my daughter. I spoke to many women in the village, tried to coax them to see how good it would be for our daughters. They will be able to read, write and count. No one will be to make a fool of her, like they do with us. They will know better ways of looking after children and homes, I said to them. But they paid no heed. Actually it was the men who were difficult to convince."

Nonetheless Babri Bai brought her daughter, Chandu, to the shivir. Chandu finished her primary education and continued to school in the village till class eight. Chandu wanted to continue school but the village school was only up to class eight, so Babri Bai sent her to Bikaner to continue school. Here, she finished her class ten and twelve. Today, she is in the final year of B.A. degree and pursuing Bachelors in Education. She wants to be a teacher. Babri Bai says proudly, "Today those same people who refused to send their daughters, regret their decisions when they see Chandu. They tell me, you were right Babri Bai. You were right about everything. Our daughters could have also had the opportunities like Chandu. Now everyone is sending their children to school. This makes me happy. One Chandu in the village has changed so many."

Swasthya Sathin in Action

The challenges cannot be fully addressed by the current formal systems of healthcare facilities. To establish and understand the role of Swasthya Sathis or CHWs, it is essential to understand the deep involvement, evolution and adaptation, of these women and the function they have played in improving and sustaining the village health and most importantly, linking it with the formal system. It is of utmost importance to comprehend the roles these women play in the frame of reference of the social milieu in which they operate and the difficulties they posed with everyday. It is also very necessary to see them in different contexts for the holistic development they have facilitated in the villages.

Health

The CHWs have been working to uplift the health standards and facilities in the villages. With remote accessibility, even immediate first aid in case of emergencies improves drastically the chances of survival and this has been the motto for CHWs and the programme. The CHWs have been working in the region for more than two decades and deeply understand the health needs and social systems. The CHWs play three essential roles in the sphere of Health.

Δ Direct delivery of services
Δ Advocacy
Δ Monitoring community Health

The CHWs are trained to provide three post natal care, conduct safe deliveries, provide information, educate and motive, immunization, growth monitoring, nutrition and family planning; treat minor ailment; identify those who require referral. Given the low levels of nutrition in the villages, they closely monitor nutrition levels in the village, especially of children and adolescent girls.

Women's health is of utmost priority. Health concerns among women are kept under wraps and are not discussed until they reach an acute stage where the implications become severe. To avoid this CHWs closely monitor women and adolescents' health. Leucorrhoea and anaemia is common among women and girls but due to the social atmosphere, this is not treated. The CHWs make sure this

and other concerns are raised and treated within time. They give iron supplements to adolescent girls. To promote sanitation and hygiene, CHWs dispense sanitary napkins. They check-up women on the onset of pregnancy and during pregnancy, they keep a close watch, to ensure the growth of the baby is right, the mother is healthy and complications are avoided.

The CHWs assist in the organization of medical camps by professional doctors and nurses, in the villages. With limited accessibility, medical camps are till date organized to provide professional medical assistance to complicated cases. Here, the CHWs play a vital role in bringing the screened patients for treatment. This improves the effectiveness and reach of the camp and the people receive necessary care and treatment.

Since the implementation of the NRHM, the health services have become the responsibility of the ANM and ASHA; the CHWs assist them in these services. Even when a delivery is about to take place, or a woman becomes pregnant or if someone falls sick the CHW is contacted first and she calls on the ANM and ASHA. This is primarily due to the years of association in the village. She assists in institutional deliveries, immunization and providing nutritional supplements also. She supports health centre activities. The ASHAs find it easier to find a footing in the village where a CHW is available. The village people are aware and sensitized towards health and health concerns and the ASHAs take the help of CHWs to reach out to people.

However, many of the villages still do not have an appointed ASHA. This is because of two main reasons, firstly, the literacy level in the villages is very low and the women do not fulfil the basic qualification of the criterion. Secondly, the ASHA works on incentive basis and this does attract attention of the women to take up the job. CHWs play a pivotal role in sensitizing people and raising awareness on various issues. They create an environment of understanding and information in place of superstitions and tantric practices, remove doubts and strengthen faith in the modern medical system. They propagate health and hygiene practices, insist on cleanliness and also encourage environmental protection for better health. They insist on clean drinking water and keeping hygiene around the village. They encourage institutional deliveries; adopting family planning measures, give necessary pre post & intra natal and childcare advice. They educate pregnant and lactating women about nutrition, monitoring it and about breast-feeding and nutritional supplements. They also advocate immunization, educate, especially to-be

"Now people call us as soon as they need any help. But when I started, I had to plead with them to take medication, come with me to the camps or to the doctor. Most difficult was to take men or women for vasectomy or Tubal ligation. But now after so many years' efforts people are realising the benefits of a smaller family. Also, now the society has become more open to this concept. I have also motivated my son to get operated. He has one son and a daughter."

and new mothers, about importance of immunization. They promote sanitation and hygiene and give even basic training about sanitary napkins, how make them easily at home and to use them regularly.

The third health function that the CHWs carry out is of monitoring the health status of the village. They keep a close watch on the health and illness patterns in the village. They are trained in maintaining a record and database for the village. This provides vitals statistics for the continued analysis of the health in the villages. As VHSC members, in some villages, they help in proper planning and implementation of health and hygiene related activities and practices

Education

Urmul has been facilitating educational programmes in the region. Over the years more than 10000 children, out of whom more than 80 % are girls, have been educated. Illiterate- the women found it very difficult to grasp and memorise medicines and information about diseases. They realised they would have had to put in much less effort than they already did had they been educated. Seeing how education impacted life and living all across, they were motivated to send their children, both boys and girls to schools. The CHWs as volunteers have since played a pivotal role in supporting and strengthening the education programmes. They helped in initiating an environment congenial to education, especially for the girl child. They, themselves, were uneducated, but working and training as CHWs, they realized the importance of education. They wanted all children to be educated so they could help explore stronger and better possibilities for them and the village. They were now more appreciated and accepted in the society because of their efforts by now. They persuaded and convinced people to send their children to school, explained to them how this would untie opportunities and was necessary for future. Few agreed and few did not. However, it did initiate the thought

in the minds of the people. They began contemplating education as an option for girls – this was the biggest achievement. Few, who understood, sent their daughters and sons, to village schools, or Urmul-run Marushalas (primary schools) and Balika Shivirs (residential education bridge camps) When these first generation of learners began to display changed attitudes and behaviour, even those who had been sceptical sent they children, both daughters and sons to school.

ECCD and Child Rights Advocacy

Care and development of children is a primary responsibility of the family, community and local governance. Urmul's engagement with early childhood initiatives is over two-decade old. It has been the implementing agency of the ICDS programme in the Kolayat block of Bikaner since 1991. This helps integrate efforts at various levels. CHWs along with the Anganwadi workers, youth forums - Kishori Prerna Manchs & Bal Manchs, Prerak Dals, VHSCs, SMCs, and SHGs, help to strengthen endeavours with the villages. Child rights and protection of these rights is of utmost importance. CHWs have played a pivotal role in scuring these, over the years. They promote early childcare and development and ensure child rights and insist that the chil

> "I have been an ASHA in the village for three years now. When I first started it was very difficult to approach all homes, especially because I'm the daughter-in-law. But because the Swasthya Saathin was there I managed to easily find my way in. It helps in cases especially where some families are adamant or superstitious and do not want to seek medical aid, there both of us go and explain. Because the CHW has been working for years people pay more attention to what she is saying and they listen more easily."

dren are sent to Anganwadi Centres to They propagate against child marriage and gender discriminations deeply embedded in the society. They work on malnutrition and creating conducive learning environments so children develop their physical, cognitive and social skills. Over the years they have been instrumental in reducing the numbers of child marriages in the villages though continuous efforts. They take part in awareness drives, village-level meetings, panchayats and the Mother-Child Health and Nutrition Day and meetings to talk to people in the village at various levels and to ensure child rights.

Living at the borders of the country, life, least said, is eventful. People and places are on the line of control and treated as 'No Man's Land'. Badu Bai lived in village Ravwala. People would come from far off villages to consult her and take her with them on their camels for deliveries. She was excellent with her hands and could take care of even the most complicated cases with confidence.

Once on route, the mobile hospital was in her village. The ANM was delivering a pregnancy. The case was complicated. The foetus was in a breach position and the ANM was finding it difficult to deliver the baby. She consulted the doctors on-board on the mobile hospital. They examined the foetal position and the mother. They realised that they needed better medical assistance. Time was passing and the case was complicating. They were readying to take the woman in labour to Bikaner- around 150 kms, to operate and deliver the baby.

Just then, Badu Bai arrived. She examined the woman and realised the situation. Using her bare hands, she massaged the woman's stomach and in the next fifteen minutes the baby was delivered. The mother and child both, were safe. Her traditional expertise and her experience were her strengths. Badu Bai used the modern procedural knowledge. She was later trained to treat various basic and endemic health ailments in her village. The possibility of making referrals for more complex cases was the biggest assistance she received in her endeavours. People trusted in her and this possibility elevated their confidence. She drew a fine balance between the traditional and the modern knowledge. She worked hard to ensure health in her border village till her demise.

Livelihood

The CHWs mobilize women to form Self-Help Groups in their villages for capacity building and empowering the women financially and vocationally. Given the unreliability of agriculture and lack of options to livelihoods, SHGs savings and access to loans supports the families at times of crises. This gives women financial space and make them a valued member in families. The SHGs also help in other development programmes, like Income Generation Programme- for women artisans embroidering for a living. They are not exploited by middlemen and generate a regular source of income this way.

"In 1988 when the programme was first initiated, the toughest task was to get the women to the Bajju campus for training. The Patriarchal society did not allow women to come out of their homes. The closed society was sceptical of the intentions of the organization. A male family member accompanied women then. Seeing the safety they would leave in a day or two, carrying with them a positive feedback to the village. This initiated the cycle of change. Over the years, the scenarios changed so much that many CHWs and other women have travelled many places with confidence.

(Pushpa Purohit, Secretary at Urmul Seemant Samiti, has been associated with CHW programme since its beginning)

The experience

In 1988, Urmul expanded its primary health care programme to the Kolayat Block of Bikaner district from Lunkaransar and Phalodi. In consonance with the objectives of the programme, local women (in most cases the Traditional Birth Attendant of the village) were chosen- firstly the women were more likely to gain the trust of people as people were used to calling them upon various instance of health concerns especially, those dealing with women and children. This provided a chance to directly monitor and evaluate the rising rates of maternal and infant mortality. Secondly, the women already had vast experience of traditional health practices and were more easily trained in modern medical techniques to gain expertise as a barefoot doctor. They were provided with a Para-surgical medical toolkit- that was well equipped for first aid with ointments, bandages and tincture and also included general health care medicines like paracetamol, Ibuprofen, Antacid, Iron and Calcium supplements, eye drops. The community health workers were also given a baby weighing scale 'salter' to monitor malnutrition in the community. Thirdly, the exposure, service, and financial assistance would improve her status in the family and community.

Initiating the programme was exceptionally difficult. Subservient status of women in society, the purdah or the veiling system and forbiddance of leaving home for women, were the biggest bar-

riers in this social environment. The programme encouraged women to step out of their villages, come to Urmul campus (in Bajju) for trainings, and make regular visits in their specified field areas. CHWs would go about each house, irrespective of the caste and class and provide healthcare services. This received much scorn from the society initially. Against social pressures, 25 women were motivated enough to undertake the responsibility of their respective villages and Dhanis. Two of these were asked to leave their community and a few dropped out owing to external pressures but 17 of them continued. When they went back, they were met with bigger challenges than just health problems. The village community was unaccepting. The prejudices held against women, the lack of understanding of health and its problems, and superstitions hindered their acceptance. After continuous efforts, the women gradually began changing the attitudes of the people towards medicine and healthcare practices. When practices and medicines began showing their impact and bettering health, the faith in them and the women grew proportionately. The consequence of this was that the women were perceived as well wishers of the community and so won the position of opinion leaders. Over time, these women have transformed and changed their societies. They have been motivating women and men all these years to join in the efforts and encapsulated an enormous indigenous support from within the communities. This innovatively localized the programme and helped further adapt and up-scale.

The CHWs underwent regular training programmes to learn various new techniques, about new medicines and also learn to identify symptoms of various diseases that affected the region at various times and to refresh, most importantly, what they already knew. Various doctors from government hospitals and head nurses conducted these trainings. In the course of time, the Swasthya Sathis or CHWs proved to be much more than mere village health workers. They volunteered to act as resource and lead persons for their villages. They volunteered to support and promote education, livelihood options, micro-finance and sanitation in the villages. Even today they stand in as an interface between Urmul and the village community, helping build a strong base within the community. They have become a reference point for information on a variety of issues; water, land rights, employment, education, etc. People trust in them and seek advice on matters of concerns.

Today, there are more than 50 of such women covering as many villages directly. Additionally they are also called on by nearby villages to provide the necessary

care, supporting the medical mainframe as well as strengthening and fortifying programmes in education, women mobilization, livelihoods, etc. These women have become a nodal point in a comprehensive healthcare delivery platform for the village. When Urmul initiated its programme in the region, almost fifty per cent of infant mortality in Rajasthan was neonatal and perinatal, resulting from lack of effective antenatal and postnatal care. This interface was then largely in the control of the "dais". The Indira Gandhi Canal project in its wake brought along with it a few drawbacks and one amongst these was the wide spread of malaria. This aggravated the already deplorable conditions of health. The communities suffered. Lack of proper medical facilities did nothing to reduce or help. The CHWs became the only resource available to check and balance the health status of `the communities. They were trained to identify and diagnose fever from malaria, carry out safer child deliveries and arrest smaller ailments. They made the necessary referrals to doctors.

Over the years, the health care facilities have improved and Government initiatives in the form of physical health care units as well as the schemes have been more accessible. Introduction of ASHA, ANM and Village Health and Sanitation Committee in the network have helped fasten the pace of improvement. These units, together, help in holistic monitoring of health in the village. The ASHA and ANM dispense regular health care and along with the VHSC keep a close watch on the status in the villages. However, there are still villages in the region that do not have an ASHA, ANM or a working VHSC in their vicinity. These communities remain vulnerable and risk-prone. The only solution, at times available, for health care facility is the one provided by the CHWs, who regularly visit and keep a check on the health of the community or village.

New Developments: NRHM

Addressing the need for a concerted targeting of health in rural India, the government introduced National Rural Health Mission (NRHM). The government of Rajasthan launched the implementation in 2006. This was to address the growing concerns of increase in communicable and non-communicable diseases coupled with poor health facilities in the rural areas and resultant high infant mortality rates and maternal mortality rates. The objective of the mission is to provide efficient and affordable health care services, to improve the rural health infrastructure, ensuring adequate presence of healthcare workforce and addressing local needs and concerns especially the concerns of alarming sex ratio and the low status of

the girl child. The NRHM provides for a flexible financial pool for innovative and need-based decentralized utilization of funds at the state level, along side conditions for planning and management at the district level. Furthermore, the creation of female Health Activists (ASHAs) and PRIs, such as village health and sanitation committees (VHSCs), as a means of fostering a true partnership between the community and peripheral health staff in achieving desired outcomes.

Nevertheless, the sheer enormity involved in servicing a population as large as ours calls for integrated macroeconomic and grassroots level efforts to improve the rural health infrastructure and address local needs and concerns. Within Rajasthan the area as is divided on topology as it is on socio-cultural background of the people. The issues become unique to the geography as well as the varied culture attached to it. Thus the 'one size fits all' phenomenon does not help resolve the issues but aggravates them.

Moreover, political and administrative will and capability of implementation of the programme along with constraints in ascertaining the required workforce further hinder the programme. The social milieu is unfavourable towards women education. It causes difficulty in the appointment of ASHAs based on the norms prescribed. Even though the education qualification is brought down to class 5 from class 10, there is acute shortage of qualified women in the villages. Further, the distances make it very difficult to achieve a full coverage of service and infrastructure. Thus it becomes essential, to understand the role the CHW play in improving the health of community.

Challenges

Despite all the efforts, public formal medical system, the NRHM and the private sector, the Kolayat block in particular is still face with major challenges. These challenges not only diminish the possibilities in the current scenario but also inhibit further growth. Few major challenges are elaborated below:

• Health Facilities and lack of easy access poses the major problem in the Kolayat block. The medical facilities are available at either the block level or at the district levels. Health situation is characterized by infrastructural constraint. There is only one tenth of CHC with beds in the Bajju sub-tehsil area, which caters about 1 lakh population supported with just 2 Primary Health Centres (PHCs). The CHC delivery room does not have the facilities for the emergency Caesarean Section. Only one private health clinic in Bajju other than the Govt. administrated health centers supports the population. Infrastructural constraints are intensified by lack of substantive health management knowledge and awareness and behavioural limitations.

• Despite the implementation of NRHM, numbers of ASHAs are limited in the villages. The ASHA is usually appointed at the Gram Panchayat level. This limits her capacity to reach all villages under the Gram Panchayat's purview regularly. The healthcare monitoring slackens.

• The limited numbers of CHWs limits their reach in the region and does not comprehensively address the enormous needs of the entire area.

• Literacy among the women in the rural areas is as low as 8.84%. Lack of literacy poses a hindrance in the access of health care, high birth rates and a large family size. The rate of anaemia is common and found in over 50% of women. This rate rises to 82.3% in new-borns. Leucorrhoea and pelvic inflammatory disease rate is very high.

• High mortality among under-5 children is primarily due to ARI, diarrhoea and vaccine-preventable diseases. Low awareness of the symptoms of the childhood diseases and its proper care and cure add to the magnitude of the problem.

• 43.7% of children below five years of age are stunted; exclusive breastfeeding and complementary feeding of children remain significant challenges (NFHS, 2005/6).High mal nutrition levels in the village increase the risk to health. The children are born underweight and the lack of sufficient nutritional supplement remains malnourished and thus prone to diseases.

• According to data by the WCD depart-

ment, there are 48,372 ICDS centres in the state, benefiting 110 lakh children. The supplementary nutrition component of ICDS is benefiting around 39.26 lakh children and preschools are benefiting 12.60 lakh children in the state.

• Socio- cultural factors make women susceptible to ill health leading to high risk pregnancies, child morbidity and mortality and reduced capacity for taking care of the child – low literacy level leading to low awareness, lowest sex ratios in the state (917, census 2001); median age of 17 years of marriage for girls (DLHS 2005-06), early pregnancy (19% women of 15-19 years were mothers or pregnant)

• 48% girls get married before the age of 18 years; with only 40% couples adopting family planning methods, frequent pregnancies and high risked child births the health of the mother further deteriorates, leading to more complications to the health of both, mother and child. The percentage of women at risk during and post pregnancy stands at 17.9% and 31.2% respectively (DLHS, 2005). The 17 percent of adolescent girls in the age group of 14-24 year olds have access to

adequate information and training on reproductive and sexual health, making the situation graver.

• According to Baseline Survey of Urmul Seemant Samitee conducted in 2009, only 23% of expectant mothers had received the right number of pre-natal check-ups (3 or more check-ups) and skilled birth attendants attended only 42% of deliveries.

• Only 16% of children in age group of 12-23 months have received complete immunization. Alarming 43.5% children were malnourished in the age below 5 yrs.

• Lack of Information in people aggravates the already deplorable conditions. People have limited knowledge about the various schemes offered by the medical and health department. Low rate and incomplete immunization and childhood illnesses are attributed to low levels of awareness among mothers/ communities.

Looking Ahead

The last twenty years, CHWs have nurtured and nourished health of the society and its people in the remote regions of the Desert. Based as they have been on significant community education and capacity building, it is not surprising that the programme has been particularly effective in generating demand for preventive and promotive health services. To a large extend they have also increased the use of prenatal care and family planning. The programme has been successful checking the high rates of maternal and infant mortality, high incidences of endemic and non-endemic diseases and disorders. It is now time to reassess the situation and pave way for the future of health in communities and CHWs as role players. Some key pointers deserving attention are mentioned ahead.

• Today, the increasing demands of health and complications require a positive restructuring of the role of community health workers in the community. These are a trained resource for health in the villages. They have built trust and confidence in the people. More adaptive and solutions based approach in the villages will further help decrease the scepticism in seeking medical advice and assistance.

• It is now, more than ever, necessary to further strengthen their capacities and to incorporate their traditional know-how with advanced trainings in primary health care. Alternative medical sciences, like Ayurveda and Unani, can be good additions to the wide base of their knowledge. Their traditional knowledge, which is entirely based on these streams, would widen the scope of their capacities.

• Sustainability is a major criterion. The women are, currently paid a small fee of Rs 800 a month, along with the money

they earn by selling medicines. Now that the state government has subsidized medicines completely, they will earn only Rs. 800. Newer avenues need to be explored for these women – possibilities of attaching them to MGNREGA or the Gram Panchayat could be explored.

• The free medicines do not reach Dhanis and remote villages and remain at the levels of PHC, CHC and ANM. To widen the reach CHWs could play a vital role. They are trained in identifying and dispensing medicines and the possibilities could be explored with the government.

• Community Health Workers are well trained, adept and equipped in providing healthcare and handling first aid in case of emergencies. Their illiteracy does not pose any threat to the health of others.

• Community health workers, at many villages are the only source of basic healthcare. Many villages do not have ASHA appointed in the villages. Some panchayats govern more than three or four villages spread over at a radius of 30-40 kilometres. In such cases, it becomes impossible for the ASHA to be available at each village. This problem aggravates during the cultivation season, when families move from the villages to their dhani (a house on the farmlands). This makes reaching them even more difficult.

• Over the years, Community Health Workers have established a trusted relationship with the communities. The communities pay attention to and follow the advice the women render them. They have been fighting the cause of social injustice, gender discrimination and child rights.

• Community health workers work along with the ASHA and facilitate their workings. Community health workers are usually older women in the village while the ASHA are usually the daughters-in-law. Given the patriarchal set up of the communities in the villages as well as the feudalistic composition, it becomes difficult for the younger ASHA to enter homes, and generate personal information about health from the families.

• Community health workers facilitate the community in mobilization and empowerment of women, childcare, livelihoods, etc. Therefore contributing to the holistic development of the entire community and village.

• Community health workers are the very essential but missing link in the formal healthcare system. Even those places that had both an ASHA and the community health worker were better in health status. The ASHA and CHW worked in unison and had a better outreach.

Dhapu Bai is fondly called Dhapu Dadi by people in Urmul, her community, her village and all who know her. She is a board member of the organisation, Urmul Seemant Samiti Bajju. This old woman is illiterate and had never travelled across the boundaries of her dhani. She had heard stories of lands of greens, prosperity and life. But for her life was living in a Dhani in a place wish-

fully called 'Chila Kashmir'. It is a piece of land covered with miles and miles of sand and is situated at the west-end of the country, bordering with Pakistan on one side. It is dry, barren and without water through out the year. Road does not reach this place and the only transport found is the camel-cart or a long walk.

Dhapu dadi was a dai in the community and was approached to work as the community health worker when the programme began. At first she was hesitant but it did not take to much convincing. She was a widow and this, she saw as an opportunity to find her financial sustenance. Dhapu dadi was among the first twenty-five women who dared to step out of home and change their worlds. She remembers going to the first training at the Urmul campus at Bajju. She found the names of the new medicine funny and difficult to remember. "It was the case with all of us. Then we learnt to recognise the shape and sizes of the different tablets and registered them to memory using these. When we first went to the villages, people did not believe in us. We had been delivering their children for years - that was fine, but when it came to treating them with medicines they said the medicines would harm them. Gradually the changes that came by with the medicines, the referrals and the camps instilled the community's faith. Today, for everything they still come to me even when I don't keep medicines anymore," she fondly narrates her journey. She has worked here tirelessly for the last twenty-five years for the health and welfare of her people. Working to change and lift the status of women in the community, leading many a crusades in the desert to awaken people towards the depleting ecology, impact of the Indira Gandhi canal on health, maternal and child care, education and livelihood.

It is here that the winds carried her songs to the lands wide and far, praying them to turn their attentions awhile to this place never reached. She sang to her countrymen in anger, agony and pain, hoping them to see life and its tales.

Annexure 1

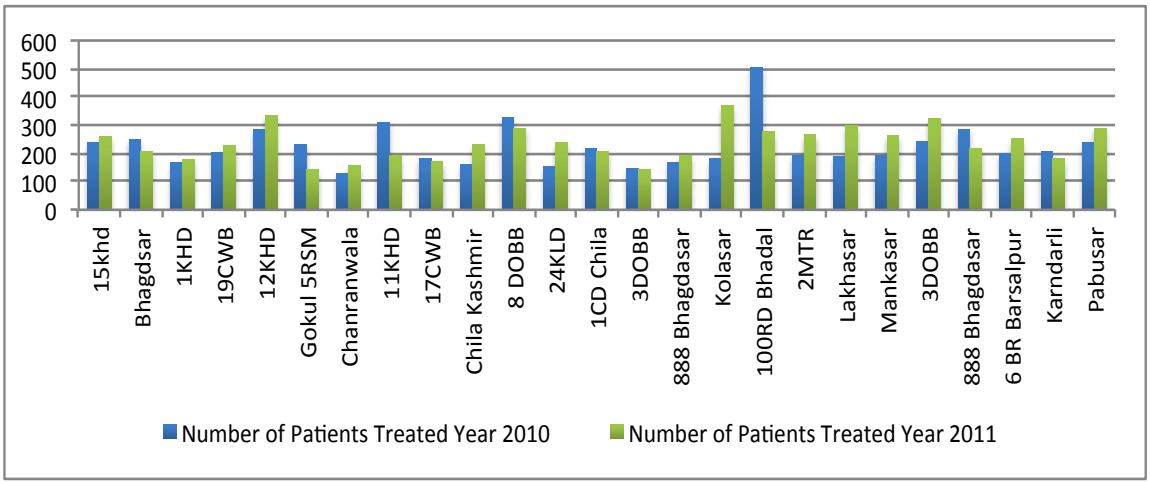
Name of CHW	Village	Patients Treated (per year)				Presence of ASHA
		2010	Month (Avg)	2011	Month (Avg)	
Jawradevi	15khd	238	20	261	22	No AWC
Kasturi Devi	Bhagdsar	251	21	206	17	Yes
Sugni Devi	1KHD	166	14	180	15	No AWC
Teji Devi	19CWB Charanwala	204	17	228	19	Yes
Noja Devi	12KHD Charanwala	286	24	335	28	No AWC
Shanti Devi	Gokul 5RSM	231	19	144	12	No AWC
Badu Devi	Chanranwala	130	11	157	13	Yes
Lakshmi Devi	11KHD Charanwala	311	26	192	16	No AWC
Sammudevi	17CWB Chanranwala	183	15	170	14	No AWC
Barju Devi	Chila Kashmir	159	13	230	19	Yes
Dhapu Devi	8 DOBB Mankasar	327	27	288	24	No AWC
Mukhi Devi	24KLD Bhurasar	155	13	238	20	No AWC
Devi	1CD Chila	219	18	206	17	No AWC
Gawradevi	3DOBB Bhagdasar	145	12	144	12	No AWC
Penpa Devi	888 Bhagdasar	167	14	191	16	No AWC
Kasini Devi	Kolasar	181	15	370	31	Yes (2 ASHAs)
Khatu Devi	100RD Bhadal	506	42	276	23	N/A
Reshma Devi	2MTR Mithadiya	194	16	266	22	No AWC
Hurma Devi	Lakhasar	190	16	299	25	N/A
Ganga Devi	Mankasar	193	16	264	22	Yes
Lali Devi	3DOBB Bhagdasar	242	20	323	27	No AWC
Parmi Devi	888 Bhagdasar	286	24	217	18	No AWC
Saraswati Devi	6 BR Barsalpur	201	17	252	21	No AWC
Santosh Devi	Karndarli	206	17	181	15	Yes
Chauthi Devi	Pabusar	239	20	289	24	N/A
Jani Devi	Miyanka	144	12	214	18	N/A
Nathi Devi	Khara Lohan	444	37	213	18	N/A
Mohini Devi	Haddan	289	24	278	23	1 out of 4

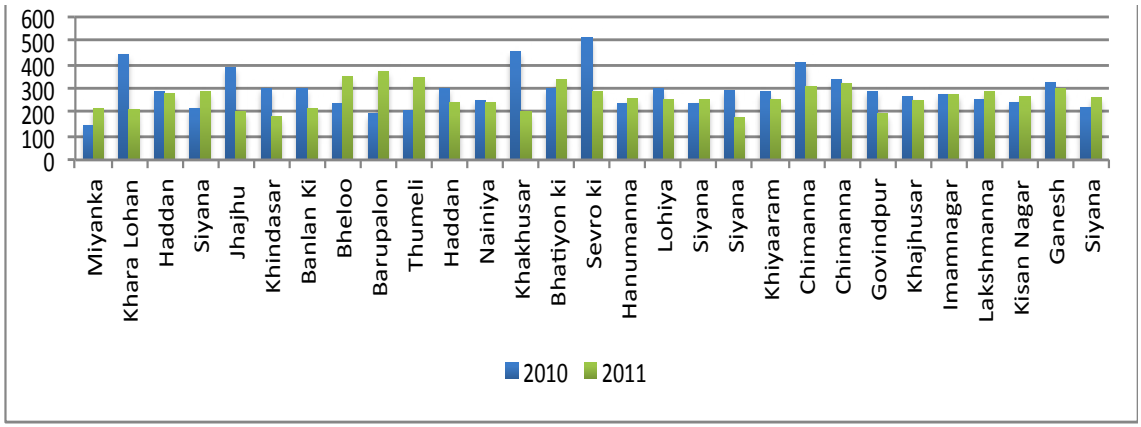
Table displaying the Work of CHWs

Name of CHW	Village	Patients Treated (per year)				Presence of ASHA
		2010	Month (Avg)	2011	Month (Avg)	
Kamla Devi	Siyana	217	36	286	24	Yes
Shayar Devi	Jhajhu	387	65	202	17	1 out of 3
Soni Devi	Khindasar	301	25	182	15	Yes
Sohan Kanwar	Banlan Ki Gol	300	25	214	18	Yes
Jamuna Devi	Bheloo	238	20	349	29	Yes
Lakshmi Devi	Barupalon Ki Dhani	193	16	373	31	Yes
Gomti Devi	Thumeli	206	17	346	29	Yes
Maghi Devi	Haddan	300	25	239	20	Yes
Rami Devi	Nainiya	250	21	239	20	N/A
Manhori Devi	Khakhusar	455	38	203	17	Yes
Nainu Devi	Bhatiyon ki Dhani	299	25	337	28	Yes
Chini Devi	Sevro ki Dhani	513	43	286	24	No AWC
Kailashi Devi	Hanumannagar - Bheloo	238	20	258	22	Yes
Khamma Devi	Lohiya	300	25	252	21	Undetermined leave
Gowra Devi	Siyana Bhatiyaan	238	20	252	21	Yes
Phooli Devi	Siyana Kundliyaan	292	24	178	15	Yes
Chunni Devi	Khiyaaram Nagar	286	24	254	21	Info unavailable
Pappu Devi	Chimanna	410	34	310	26	Info unavailable
Sua Devi	Chimanna	337	28	322	27	Info unavailable
Jamuna Devi	Govindpur	289	24	194	16	Info unavailable
Nasiba Devi	Khajhusar	266	22	250	21	Info unavailable
Moomal	Imamnagar	276	23	275	23	Info unavailable
Nainu Devi	Lakshmannagar	254	21	286	24	Info unavailable
Jamuna Devi	Kisan Nagar	241	20	265	22	Info unavailable
Radha Devi	Ganesh Nagar	325	27	299	25	Info unavailable
Gawra Kanwar	Siyana	222	19	263	22	Yes

Table displaying the Work of CHWs

Annexure 2


600
500
400
300
200
100
0
15khd
Bhagdsar
1KHD
19CWB
12KHD
Gokul 5RSM
Chanranwala
11KHD
17CWB
Chila Kashmir
8 DOBB
24KLD
1CD Chila
3DOBB
888 Bhagdasar
Kolasar
100RD Bhadal
2MTR
Lakhasar
Mankasar
3DOBB
888 Bhagdasar
6 BR Barsalpur
Karndarli
Pabusar
Number of Patients Treated Year 2010
Number of Patients Treated Year 2011


600
500
400
300
200
100
0
Miyanka
Khara Lohan
Haddan
Siyana
Jhajhu
Khindasar
Banlan Ki
Bheloo
Barupalon
Thumeli
Haddan
Nainiya
Khakhusar
Bhatiyon ki
Sevro ki
Hanumanna
Lohiya
Siyana
Siyana
Khiyaaram
Chimanna
Chimanna
Govindpur
Khajhusar
Imamnagar
Lakshmanna
Kisan Nagar
Ganesh
Siyana
2010
2011

The Charts illustrates the current pattern of health status in the villages were the programme is operational. It highlights the number of patients treated and referred by the CHWs in the villages in a year. It also draws attention to the presence of ASHA in the villages. It highlights the fact that despite the presence of an ASHA, the CHW still plays a vital role in treating patients in the villages for common diseases and referring them in case of acute cases. Where there are still no ASHAs, CHWs are the only possible response to all health related issues in the desert.

Key pointers

• The number of patients treated in a year vary between a minimum of 159 and as high as 513 – displaying the varied status of health in the region.
• The average number of cases of the total villages decreased by 4%
• 44% villages showed a rise in number of cases in the 2011 when compared to the 2010 due to lack of services and ease of accessibilities
• 33% villages showed a fall in the number of cases. The fall in numbers is significantly high- Bhadal, Khakhusar, Khara Lohan, Sevro ki Dhani, Khindasar, Chimana specifically. Four of these villages do not have any formal health services and rely only on CHWs.
• 37% percent villages in the programme area do not have an ASHA
• 8% percent of villages have under appointment of the number of ASHAs required in the village. Many villages have an Anganwadi Centre, but no appointed ASHA

Over 25 years,
the programme has been
supported by:

Aga Khan Foundation

Border Area Development Programme,
Ministry of HRD, GoI

CAD IGNP
World Food Programme

ActionAid

Plan International

Plan India

evi, Dhapu Devi, Kisturi, Noja Devi, Sugani Devi, Chothi Devi, Kishani, Lala Devi, Badu
Samu Devi, Nenu Devi, Pappu Devi, Mumal, Radha Devi, Sua Devi, Chuni Devi, Jamana
Ganwara Devi, Shohan Kanwar, Khama Devi, Mohini, Maghi Kanwar, Phuli Devi, Jyani
khi Devi, Santosh Devi, Khatu Devi, Shakari Devi, Jawara Devi, Tijan, Laxmi, Shanti Devi,
, Premi Devi, Hurma Devi, Ganwara Devi, Ganga Devi, Devi, Barju Devi, Reshami, Samu
asiba, Shayar Devi, Kailashi Devi, Jamana Devi, Nathi Devi, Laxmi Devi, Gomati, Ganwara
hi Devi, Nenu Devi, Kamala Devi, Rami Devi, Vidha Kanwar, Muli Devi, Mukhi Devi, San-
Kisturi, Noja Devi, Sugani Devi, Chothi Devi, Kishani, Lala Devi, Badu Devi, Premi Devi,
evi, Pappu Devi, Mumal, Radha Devi, Sua Devi, Chuni Devi, Jamana Devi, Nasiba, Shayar
Kanwar, Khama Devi, Mohini, Maghi Kanwar, Phuli Devi, Jyani Devi, Chhini Devi, Nenu
atu Devi, Shakari Devi, Jawara Devi, Tijan, Laxmi, Shanti Devi, Dhapu Devi, Kisturi, Noja
i, Ganwara Devi, Ganga Devi, Devi, Barju Devi, Reshami, Samu Devi, Nenu Devi, Pappu
ashi Devi, Jamana Devi, Nathi Devi, Laxmi Devi, Gomati, Ganwara Devi, Shohan Kanwar,
amala Devi, Rami Devi, Vidha Kanwar, Muli Devi, Mukhi Devi, Santosh Devi, Khatu Devi,
gani Devi, Chothi Devi, Kishani, Lala Devi, Badu Devi, Premi Devi, Hurma Devi, Ganwara
nal, Radha Devi, Sua Devi, Chuni Devi, Jamana Devi, Nasiba, Shayar Devi, Kailashi Devi,
evi, Mohini, Maghi Kanwar, Phuli Devi, Jyani Devi, Chhini Devi, Nenu, Mukhi Devi, San-
Kisturi, Noja Devi, Sugani Devi, Chothi Devi, Kishani, Lala Devi, Badu Devi, Premi Devi,
evi, Pappu Devi, Mumal, Radha Devi, Sua Devi, Chuni Devi, Jamana Devi, Nasiba, Shayar
Kanwar, Khama Devi, Mohini, Maghi Kanwar, Phuli Devi, Jyani Devi, Chhini Devi, Nenu
atu Devi, Shakari Devi, Jawara Devi, Tijan, Laxmi, Shanti Devi, Dhapu Devi, Kisturi, Noja
i, Ganwara Devi, Ganga Devi, Devi, Barju Devi, Reshami, Samu Devi, Nenu Devi, Pappu
ashi Devi, Jamana Devi, Nathi Devi, Laxmi Devi, Gomati, Ganwara Devi, Shohan Kanwar,
amala Devi, Rami Devi, Vidha Kanwar, Muli Devi, Mukhi Devi, Santosh Devi, Khatu Devi,
gani Devi, Chothi Devi, Kishani, Lala Devi, Badu Devi, Premi Devi, Hurma Devi, Ganwara
nal, Radha Devi, Sua Devi, Chuni Devi, Jamana Devi, Nasiba, Shayar Devi, Kailashi Devi,
vi, Mohini, Maghi Kanwar, Phuli Devi, Jyani Devi, Chhini Devi, Nenu Devi, Kamala Devi,
evi, Jawara Devi, Tijan, Laxmi, Shanti Devi, Dhapu Devi, Kisturi, Noja Devi, Sugani Devi,
nga Devi, Devi, Barju Devi, Reshami, Samu Devi, Nenu Devi, Pappu Devi, Mumal, Radha
i, Nathi Devi, Laxmi Devi, Gomati, Ganwara Devi, Shohan Kanwar, Khama Devi, Mohini,
i, Vidha Kanwar, Muli Devi, Mukhi Devi, Santosh Devi, Khatu Devi, Shakari Devi, Jawara
evi, Kishani, Lala Devi, Badu Devi, Premi Devi, Hurma Devi, Ganwara Devi, Ganga Devi,
a Devi, Chuni Devi, Jamana Devi, Nasiba, Shayar Devi, Kailashi Devi, Jamana Devi, Nathi
Kanwar, Phuli Devi, Jyani Devi, Chhini Devi, Nenu, Pappu Devi, Mumal, Radha Devi, Sua
Devi, Laxmi Devi, Gomati, Ganwara Devi, Shohan Kanwar, Khama Devi, Mohini, Maghi
Kanwar, Muli Devi, Mukhi Devi, Santosh Devi, Khatu Devi, Shakari Devi, Jawara Devi, Ti-
i, Lala Devi, Badu Devi, Premi Devi, Hurma Devi, Ganwara Devi, Ganga Devi, Devi, Barju
i Devi, Jamana Devi, Nasiba, Shayar Devi, Kailashi Devi, Jamana Devi, Nathi Devi, Laxmi
Devi, Jyani Devi, Chhini Devi, Nenu, Tijan, Laxmi, Shanti Devi, Dhapu Devi, Kisturi, Noja

Carriers of change

The CHWs played a vital role in changing the societal make up of their communities. They organised their communities and educated them on bettering the living, motivating them to take the ownership of health, education and livelihoods. The women have removed their social veils and made space for themselves and other women in the society. The anecdotes of the women and the Urmul team draws from the various experiences and elucidated the changes they brought to their own lives. The women drove the change by setting an example themselves for others to watch, learn and replicate.

Urmul Seemant