Special Section Commentary

Implementation of the Meikirch Model in Odisha, India

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Abstract The National Youth Service Action and Social Development Research Institute (NYSASDRI) has been implementing the Meikirch Model in 100 villages in the state of Odisha where rates of poverty, infant and maternal mortality are the highest in India. Although no formal evaluation yet exists, NYSASDRI staff have monitored 20 villages closely and associate great improvements in sanitation, malaria prevention, immunization, and nutrition with implementation of the Meikirch Model. NYSASDRI engaged in implementation with villagers and elders and with growing support of health practitioners, government officials, people's representative, media, social activists, and functionaries of other non-governmental organizations.
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I lead the National Youth Service Action and Social Development Research Institute (NYSASDRI), a voluntary organization that has been working with rural poor and disadvantaged communities for their overall development since 1985. We have initiated work in health, education, environment, rehabilitation, community empowerment, research, and we advocate on behalf of communities in these areas. NYSASDRI also pioneers in managing primary health centers and in providing support for people with disabilities, including autism. The United Nations recognizes NYSASDRI as a Non-Government Organization (NGO).

In September 2011, I met Dr Johannes Bircher from the University of Bern, Switzerland at the United Nations Department of Public Information Annual Conference in Bonn, Germany. I found Dr Bircher's poster and explanation of the Meikirch Model of Health[1] (Model) interesting

for my organization, particularly for self-care of poor people. I also was personally interested to know what *health* is and how to remain healthy.

Odisha is a predominantly rural state of India. According to the 2011 census, the total population is close to 42 million with a more than average concentration of *Scheduled Tribe* (22 per cent) and *Scheduled Caste* (17 per cent) populations. These terms describe historically disadvantaged people.[2] During the period of British rule in the Indian subcontinent, they were known as the *Depressed Classes*, and upon liberation specifically recognized by India's Constitution. Of all states in India, Odisha has the highest rates of infant and maternal mortality, and the greatest number of people below the poverty line. More than 83 per cent of the inhabitants of Odisha live in rural areas. Literacy rate is 73 per cent.[3]

I decided to implement this Model in Odisha if Dr Bircher could give us the necessary support. He consented and came to Odisha (31 January–15 February 2012). He prepared a manual about the Model[4] and we used it in conducting many seminars, workshops, and field area visits during his time with us. Members of our community and officials up through the state level offered feedback and suggestions. The Honorable Governor of Odisha was very open, positive, and supportive about making use of the Model.

How We Implement the Meikirch Model

We printed the manual in English and Oriya, the local language, and posted it on the Meikirch Model website (www.meikirchmodelodisha.org/english_publication.html). We then engaged the NYSASDRI staff in learning about this Model – to build their capacity to work with community members to improve the health of individuals and of our entire community. We also organized meetings with state and district governments about how we wanted to make use of the Model and found them open to this innovation. They assured full support. NYSASDRI also arranged many workshops to share the Model with other stakeholders including health practitioners, government officials, people's representatives, media, social activists, and functionaries of other NGOs – through which more than 1200 people participated in the process.

This expanded group introduced the Model in 100 villages in the area around the town of Dhenkanal in the spring 2012. We selected 20 villages for more detailed teaching and observed them closely. We focused on practical activities – as we describe below. NYSASDRI also implemented the Model in our own schools so that students would begin to take advantage of the approach to health from childhood. In turn, the students can teach their parents and younger siblings. At five national conventions, meetings on health or various development aspects in Odisha and New Delhi, we discussed the Model and distributed the manual.

So far no formal research studies on the effects of the Meikirch Model have been conducted. For more than 20 years, however, NYSASDRI has assumed responsibility for the development of these villages and has a regular and close contact with their people in order to observe their evolution and their specific needs. Results reported here were observed and collected informally by my co-workers and myself during ordinary visits to these villages that include interactions with the villagers and their elders. Our primary concerns were with population-level outcomes rather than with those of individual members of these communities.

Results

Most importantly, my co-workers and I observed in the 20 priority villages that villagers developed a new motivation to care for their own health. They understood they could do something

for their health and were are able to assume much responsibility, as follows:

- Many built latrines and stopped walking barefoot near their latrines to reduce contact with human fecal matter.
- Many stopped the regular use of chloroquine and quinine and started to sleep under mosquito nets to prevent malaria.
- Many took mother and childcare much more seriously. The improvement of childhood vaccination rates from about 20 per cent to nearly 100 per cent has been particularly striking.
- Many improved their nutrition by adding fresh vegetables to a diet otherwise limited to rice.

We followed NYSASDRI's activities to engage governmental and non-governmental organizations and other institutions at higher levels with the Meikirch Model and formed the impression that many participants viewed the Model and the work based on it with much interest. Its impact, however, has not yet been assessed. In several organizations people spoke about health and mentioned the concepts of the Meikirch Model even without reference to its origin (the organization, NYSASDRI, or the Manual).

Conclusions and Next Steps

NYSASDRI has been active in health for more than 20 years, but we have never encountered such progress. This project has been very gratifying for all involved. Currently we are planning formal studies of the effect of the Meikirch Model.

For improving health care and public health practices, we now share the Model with Village Health and Sanitation Committees (Goan Kalyan Samit), Integrated Child Development Workers (ASHA workers), Women Self-help Group Members, Forest Protection Committee Members, and the Five Village Wise and Respected Elders (Panchayat Raj Institution Members), and health practitioners.

About the Author

Sarangadhar Samal is Director of the National Youth Service Action and Social Development Research Institute in Odisha, India. The organization started in 1985 and adopted the Meikirch Model in 2012.

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