Case Study – July 2022

Agents of Change Beyond Healthcare: Lessons from the *Mitanin* (Community Health Worker) Program in India

Suchi Pande

Accountability Research Center

About Accountability Research Center (ARC)

The Accountability Research Center (ARC) is an action-research incubator based in the School of International Service at American University. ARC partners with civil society organizations and policy reformers in the global South to improve research and practice in the field of transparency, participation and accountability. See: www.accountabilityresearch.org.

About Sandwich Strategy Research

This case is published in a series of studies that contribute to ARC's comparative analysis of "sandwich strategy" reforms, with support from the John D. and Catherine T. MacArthur Foundation's on Nigeria program. For additional cases, see: https://www.macfound.org/press/grantee-publications/top-down-ground-up-creating-accountability-with-sandwich-strategies.

"Sandwich strategies" are interactive processes in which reformers in government tangibly enable citizen action from below, potentially bolstering coalitions for change. This comparative study seeks to identify diverse reform pathways, roadblocks and outcomes. See: https://accountabilityresearch.org/sandwich-strategy-research/.

About ARC Publications

ARC publications serve as a platform for accountability strategists and researchers to share their experiences and insights with diverse readers across issue areas and sectors. These publications frame distinctive local and national initiatives in terms that engage with key issues in the transparency, participation and accountability field.

Rights and Permissions

Notes on Support

Support for ARC comes from the William and Flora Hewlett Foundation, the John D. and Catherine T. MacArthur Foundation, Open Society Foundations, and the David and Lucile Packard Foundation. ARC's work is also made possible by institutional support from the School of International Service, American University.

About the Authors

Suchi Pande is a scholar in residence at the Accountability Research Center. She has extensive research and practical experience in the field of social accountability, including implementing right to information laws and public oversight processes, consultancies with international organizations, leadership of action-research initiatives at American University in the US, and doctoral research at the Institute of Development Studies at the University of Sussex in the UK. Before joining ARC, Suchi worked with the National Campaign for People's Right to Information, and the Mazdoor Kisan Shakti Sangathan in India. She is currently researching national grievance redress mechanisms in the public sector.

Contents

Acronyms 4
Introduction 4
Preliminary Opening from Above 7
Creation of a Semi-Autonomous State Agency to Support Mitanins 8
Role of the State Health Resource Center (SHRC) 10
Conclusion 15
References 17
Notes 19

Acronyms

AAS	*Adivasi Adhikar Samiti*
ASHA	Accredited Social Health Activist
EU	European Union
NRHM	National Rural Health Mission
SHRC	State Health Resources Center

Introduction

In 2002, the state of Chhattisgarh, India launched a community health worker or Mitanin Program. Following prior openings from above—the creation of a new state—a reformist bureaucrat in the health department provided financial, technical, and social support to organize women from marginalized groups to secure their rights, most directly to healthcare. This case study documents the government-run Mitanin Program which created a semi-autonomous agency to support and train women volunteers from socially excluded groups with an activist approach. In coordination with the support agency, *Mitanins* consistently adopted roles that go beyond health program-specific interventions, raising awareness on rights to food, nutrition, and employment, forest rights, and violence against women.

In 2000, the new state of Chhattisgarh was created from erstwhile Madhya Pradesh. The Mitanin[1] Program was established in 2002 in one of India's poorest states. The central Indian state of Chhattisgarh is a richly forested, mineral-rich state, accounting for "Sixteen percent of the country's reserves of coal, nineteen percent of its iron ore, twenty-eight percent of its diamonds, eleven percent of its dolomite and thirty-eight percent of its tin ore" (Tillin 2013, 36). Yet, it is one of India's poorest states. In 2005-2006, Chhattisgarh was the fifth poorest state; over the next decade, it improved to seventh poorest (OPHI 2020). It is also one of the states experiencing an ongoing armed insurgency led by Maoists (a Marxist-Leninist group) that frequently results in bloody skirmishes with the Indian state.[2]

Despite these structural conditions, a high percentage of Adivasi or indigenous population,[3] and ongoing struggles over natural resource extraction and land conflicts, since the early 2000's, state governments instituted successful reforms: pro-poor health sector reforms, including the well-functioning Mitanin Program (Nandini and Schneider 2014; Champa 2017); improvements to the large-scale food subsidy program (Joshi, Patnaik, and Sinha 2019); and the reduction of corruption by eight-two percent (Champa 2017). "Huge strides" were also made in reducing malnutrition and

inadequate sanitation (OPHI 2020). With these and other 'pro-poor changes', during the decade of 2005-2006 to 2015-2016, the state's multidimensional poverty index (MPI) "more than halved (0.355 to 0.153) (OPHI 2020).[4]"

New statehood provided the motivation for politicians and bureaucrats to do "something new."[5] The creation of the new state also attracted the interest of international actors such as the European Union (EU) and the international non-governmental organization ActionAid's India chapter. The EU's main focus was the creation of public-private partnerships in the health and education sectors.[6] The EU, ActionAid India, and the new state government of Chhattisgarh jointly funded the Mitanin Program (SHRC 2003). An enabling environment for the Mitanin Program was created by a reformist bureaucrat from the health department, a high-level civil servant with a track record for pro-poor initiatives, and a professor of medicine teaching at the national health research institute. The latter was a key figure in designing the Mitanin Program and imbuing it with movement-oriented principles.[7]

The Mitanin Program is not the first Community Health Worker (CHW) program in India, but previous programs did not enjoy the type of financial, technical, and social support from the state as the Mitanin Program.[8] According to one of the key coordinating figures of the Mitanin Program at its inception, the high-profile launch of the Mitanin Program signified a high degree of political commitment. The chief minister "visibly and publicly" associated himself with the program and called on high-ranking civil servants to treat the program as government priority (SHRC 2003, 35). After the initial pilot in fourteen blocks, the Mitanin Program was aggressively expanded across the state. It was felt that if the program was big enough it would be hard to dismantle: "The size gives it protection… [it is] not easy to dismantle because it is huge, dispersed and old"(SHRC leader cited in Nambiar and Sheikh 2016, 129). The Mitanin Program spread to all rural areas within two years of its launch, and currently covers twenty-four million people across 20,000 villages and 3,800 urban slums (Garg and Pande 2018).

The Mitanin Program is run and coordinated largely by women: one hundredpercent of *Mitanin*, eight-five percent of trainers, seventy percent of mid-level workers, and forty-seven percent of coordinators are women (Champa 217, 47). The stated objectives of the Mitanin Program are to: 1) organize women and weaker groups to secure their rights related to health, and 2) promote involvement of locally elected bodies (panchayats) in the health sector and facilitate systematic local health planning and action (SHRC cited in Garg 2017). Mitanins are selected by the community from the local population. Their selection is approved by local village councils or panchayats (Nandi and Schneider 2014). Nearly 70,000 women Mitanins, most of them Adivasi women, provide health support, covering almost all rural habitations and urban slum areas (Garg 2017). These Mitanin work in collaboration with other frontline workers of government sponsored nutrition schemes such as the *Anganwadi* (or rural mother and child health center) Workers under the Integrated Child Development Scheme as well as the Auxiliary Nurse and Midwife.

Unlike their predecessor community health workers, Mitanins were intended to be activists performing dual roles: health educators as well as community organizers (SHRC 2003). Mitanins are supported by a "boundary organization": the State Health Resource Center or SHRC (Schaaf et al 2018; Gustafsson and Lidskog 2018). The SHRC is an autonomous entity. Its members include state and civil society actors. Its purpose is to provide 'technical capacity' to the government of Chhattisgarh for designing health-sectors reforms, including community-based health programs such as the Mitanin Program. Yet, it has the 'flexibility' to draw on such expertise from both government and advocates and practitioners of community action in civil society (SHRC 2003, 28). The SHRC's unique contribution to the Mitanin Program is developing a preemptive

and uncommon learning strategy, helping the program adapt to policy and electoral changes, and prioritizing social mobilization and a movement building approach (Garg and Pande 2018). This uncommon approach has helped the SHRC to continuously strategize and manage, to the extent possible, one of the main constraints of community health worker programs: balancing their roles as service providers and community leaders.[9]

To ensure the program survives electoral changes, the SHRC ensured the Mitanin Program avoided overt political patronage while maintaining constructive engagement with government functionaries and ministers. At the launch of the state government's health program in 2001, the Mitanin Program was named after a politician (Indira Swasthya Mitanin Program).[10] Two years later, in 2003, the program was generically renamed to avoid the identification of the program with an individual or party (Nambiar and Sheikh 2016, 128). From its inception, strategies focused on mobilizing communities, creating synergies with the public health system, andintegrating human resources across health and nutrition programs.

The SHRC engaged in tangible actions to align Mitanins' work with change agendas of autonomous mass organizations. For example, starting with a limited focus on health related activities, the SHRC helped the Mitanins evolve their activities to include rights-based work on food security and natural resource extraction. On both these fronts, Mitanins built alliances with broad-based movements such as the national Right to Food campaign. Each of these strategies brought together state and civil society to support the Mitanins' health education activities and leadership development. Learning from its predecessors as well as emerging initiatives in other states (such as Center for Enquiry into Health and Allied Themes in Maharashtra, *Prayas* in Rajasthan), the program emphasized that a Mitanin was a "health activist, someone who mobilizes the community for a more accountable public health system" (SHRC 2003, 26) rather than a link worker or government employee. She was viewed as an intrinsic part of the health system rather than an informal worker at the periphery of the public health system. The focus was on linking the program objective of strengthening the public health system and a Mitanin's work so that both aspects mutually reinforced each other. By combining activism with health education and leadership training, the redesigned Mitanin Program was a way to "let the community in (SHRC 2003)."

How did the Chhattisgarh state government agree to engage local communities in pro-poor health sector reform? Who are the actors within government and civil society that are responsible for the development of the Mitanin Program? What did they do to develop and implement the Mitanin Program and its continuing adaption and growth? Below we document some of the contributing factors that led to the development of the Mitanin Program and the strategies used by state and civil society actors to design and implement pro-poor health policy reform, focusing on the empowerment of marginalized women, and to mobilize collective action for strengthening public health systems. We describe how state and civil society actors used openings from above[11] as well as learning from existing community health worker experiences to redesign the Mitanin Program. We trace iterative cycles of convergence and conflict to examine who did what, when and how at each turning point to include disenfranchised social groups and promote mutually reinforcing interactions between pro-reform actors in both state and civil society.

Preliminary Opening from Above

The Mitanin Program benefitted from two instances of opening from above. The first was a prior opening, in 2000: new statehood for Chhattisgarh and the presence of a reformist civil servant who provided financial, technical and social support for the Mitanin Program. The second was the launch of a national health policy in 2005 that institutionalized the position of a community health worker. We discuss the prior opening at the sub-national level and the contributing factors that led to the development of the Mitanin Program, including the creation of a support semi-autonomous state agency that mediates between the health bureaucracy and the Mitanins.

In 2000, the new state of Chhattisgarh separated from the central Indian state of Madhya Pradesh. This represented an opportunity to "identify a development agenda focused on the social sector and services" (Nambiar and Sheikh 2016, 127). According to a member of the State Health Resource Center, with the creation of a new state there was a 'political expectation that the government will do something new.'[12] The health secretary (a high-level civil servant), also a doctor by training and with some experience with community health worker programs, was interested in doing something on health. He invited other reformists in civil society to launch the state government's Mitanin Program to ensure 'people's participation' in public health.[13]

So, why did bureaucratic and political elites focus on large-scale pro-poor health reforms? There were three reasons. First, the creation of the new state of Chhattisgarh provided the necessary political commitment to undertake comprehensive health sector reforms. The State Health Secretary (Alok Shukla) familiar with the Indian CHW experience was amenable to instituting health sector reforms. He invited health activists to "lead efforts" to strengthen the health system (Champa 2017). According to another high-level bureaucrat in the new government, "there was a lot of energy [and recognition of] the need to do something…and health was on the agenda" (cited in Nambiar and Sheikh 2016, 217). Second, the new state of Chhattisgarh inherited a sparsely staffed State Department of Health and Family Welfare (Champa 2017). With high illiteracy, inadequate health centers to service rural population dispersed over 54,000 habitations, and the second highest infant mortality rate in the country (Sundararaman 2007), the state of Chhattisgarh needed comprehensive health sector reforms. Third, the ideological motivations of the key reformists allowed them to shape the focus of the government's pro-poor reform agenda. These reformists would broaden that agenda by creating a CHW program to strengthen people's participation in the health sector reforms, and more importantly to build a cadre of community organizers from within the people who use the public health system. The inspirations for this agenda lay in the past experiences of some of the reformists such as T. Sundararaman who participated in earlier renditions of CHW programs in other states as well as the mass literacy movement in the southern Indian state of Kerala, led by a voluntary organization (Kumar 1993).

As Sundararaman notes, in the initial phase, the Mitanin selection process used local cultural idioms, songs, and people's theatre to ensure outreach to its intended audience (SHRC 2003). These are elements of a *kalajatha* or traveling troupe developed during the mass literacy campaigns of the nineties to convey program objectives (SHRC 2003). According to Nambiar and Sheikh (2016, 129-130), as the program evolved SHRC recruited "those with health experience and those having prior experience with mass mobilization and community action, independent of health. Various key figures in the initial upper management of the SHRC had experience in adult literacy mobilization in north India. Others who joined the program reported prior work

in people's movements, including the literacy movement, the people's science movement, and other initiatives. For example, a Swasthya Panchayat Fellow reported working as part of the water, forest, land movement (*jal, jangal, jameen*) in the late 1990s, later joining SHRC through his networks with another community activist who had by then "joined the SHRC fray."

The creation of a new state also attracted the interest of international agencies. According to a member of the SHRC, the European Union "came in initially with the idea to put up shop in a new state." [14] Their main focus was funding public-private partnerships in the health and education sectors. Sundararaman, "convinced them" to support the Mitanin Program and the state health secretary "steered them away from public private partnerships." [15] For funding, the government of Chhattisgarh made a "policy decision to utilize funds available under the European Commission supported sector investment program" (SHRC 2003, 35). ActionAid India became the coordinating agency for the health sector reforms, and contributed financial and other resources towards initial startup of the Mitanin Program. The lead coordinator from ActionAid India—well connected to civil society outside of Chhattisgarh—was given the responsibility of negotiating with local government and civil society.

A workshop was organized in January 2002 jointly by the state government and ActionAid India. Leading health activists from across the state and country and representatives of the European Commission participated in the workshop. There was "wide ranging consensus" among participants for broader structural reform—changes in existing laws, policies, programs and institutions—before launching the Mitanin Program (SHRC 2003,). The government of Chhattisgarh agreed to the suggestion for broad health sector reform and moved to formally collaborate with leading health non-governmental organizations in the state.[16]

Creation of a Semi-Autonomous State Agency to Support Mitanins

The first iteration of state-society collaboration was the formation of a State Advisory Committee comprising state officials, non-governmental organizations, and funding agencies (EU and Danida) to advise the state government on health sector reforms. Care was taken to involve non-governmental organizations with past experience of working on policy. This effort was coordinated by ActionAid India with whom the state government signed a memorandum of understanding (SHRC 2003). However, this Committee was quickly marginalized in key decision-making processes, and eventually no meetings were held for over a year (Champa 2017). This committee eventually stopped meeting in its formal capacity and was no longer advising the state government (Nambiar and Sheikh 2016).

A second, successful, attempt led to the creation of the State Health Resources Center (SHRC) (Champa 2017; Nambiar and Sheik 2016). The SHRC is a state-civil society partnership organization of public health professionals. It was established for the purpose of facilitating policy-making and with the objective of facilitating interaction among involved stakeholders. In this

sense the SHRC is a 'boundary organization' as it facilitates the participation of actors from "both sides of the boundary" (state and civil society) as well as "professionals who perform a mediating role" (Gustafsson and Lidskog 2018, 5). According to T. Sundararaman, SHRC's first Director, the Government of Chhattisgarh and ActionAid India created the SHRC "for the implementation of the Community Health Worker Program (Mitanin) and carrying forward the pro-poor reforms proposed under the Sector Investment Program" (SHRC 2003, 33). Before the launch of the Mitanin Program, the core team of SHRC researched past experiences to learn from the strengths and limitations of some NGO-run programs (like funding constraints, prioritization of prompt curative care over preventative aspects, unclear relationship between the CHW program and the public health system) as well as government-run community health worker programs (like slowness to innovate, understaffing, and uneven quality of motivation in functionaries). According to Sundararaman, the Mitanin Program hoped to forge "state civil society partnerships" at all levels of the program as the "cornerstone of its strategy" (SHRC 2003, 27) to address some of these challenges of its predecessor community health worker programs.

The creation of the SHRC was an institutional innovation missing from previous government-run community health worker programs. Earlier community health worker programs were managed and implemented by the Department of Health and Family Welfare. According to a former SHRC leader "because most of the leadership had gone to the state from which Chhattisgarh was formed, it was easy to justify the requirement for an institution like SHRC (cited in Nambiar and Sheikh 2016, 128). Another government official pointed out, there was need for "an institutional framework. We felt it could not be solely government or solely civil society. That's how SHRC was born" (government official, male, interviewed 14 March 2012, cited in Nambiar and Sheikh 2016, 128).

According to Sundararaman, the first director of SHRC, the Chhattisgarh government authorized the creation of a functionally autonomous SHRC to 1) provide technical capacity to the Department of Health and Family Welfare in designing health-sector reform; 2) develop operational guidelines for the implementation of the reform program and 3) provide ongoing technical support to the district health administration (SHRC 2003). During the first three years, the funding for SHRC was provided through the memorandum of understanding with ActionAid, and later through a memorandum of understanding with the State Health Society. The SHRC, thereafter received funding from multiple donors, including the National Rural Health Mission, the state government and private donors (Nambiar and Sheikh 2016).

The SHRC is not obligated to accept all tasks assigned by the state health department. While it does not operate under the direct control of the health department, the SHRC does not have any control over government officers or implementing authorities. In choosing institutional autonomy in combination with an advisory role, the SHRC leadership preempted the power contestation that usually emerges from the creation of parallel authorities. According to the SHRC, its strength lies in providing inputs and its ability to internally leverage processes of change (www.shrc.org). Their 'outsiderness' makes the Mitanin Program seem like it is actually not run by the government (Mishra 2011, 36). From the beginning the SHRC prioritized selection, training, and support of locally placed female Mitanins (Namibar and Sheikh 2016) as well as carrying forward advocacy for the program (Sundararaman 2003).

The governing body of the SHRC continues to be chaired by a civil society representative and most of its members are from civil society organizations (Champa 2017). It also includes representatives from the health department. An evaluation study notes there is a strong perception within government that since the Mitanin Program was started as an initiative of the SHRC,

they are responsible for it (Misra 2011). The SHRC plays a significant role in the management and implementation of the program. While the SHRC staff are not government employees, they share power and work with government functionaries. Unsurprisingly, SHRC's autonomy and power threatens many government functionaries. Though officials admitted that it would not have been possible to run the program in its current form without the SHRC staff and field coordinators (Mishra 2011). Thus, the SHRC possesses significant influence over the Mitanin Program. It has constructively engaged state government functionaries and Ministers including in years when national and state governments were administered by rival political parties, and successfully stewarded the program and helped it survive "four Directors [of Medical Services], two CMs [Chief Ministers] and three elections" (former SHRC collaborator cited in Nambiar and Sheikh 2016, 129).

Role of the State Health Resource Center (SHRC)

The SHRC is a semi-autonomous organization created directly by the Mitanin Program. Its autonomous positioning contributed greatly to the how the program emerged and the role Mitanins play as health providers and community leaders (Champa 2017). The Mitanin Program was India's first attempt at "state-initiated community activism" with an all-female workforce promoting collective action to support community demands for entitlements from the state (Dost 2014, 209). SHRC's reform agenda was the delivery of community health services through "a program of selection, training, and support to locally placed female community health workers or Mitanins" (Nambiar and Sheikh 2016, 125).

Building Mitanins' capabilities for collective action

A key mechanism characterizing SHRC's stewardship of the program was an emphasis on developing both technical as well as social components of Mitanins' work. "Technical aspects of the program…included preventive and promotive public health, medical competencies, as well as health systems strengthening. On the other hand, social expertise, including the ability to move around, negotiate with different stakeholders, and assert oneself constructively with communities and officials alike, was also important" (Nambiar and Sheikh 2016, 129).

As Nandi and Schneider (2014) note, Mitanins' ability to engage in healthcare work and on other community priorities such as forest rights and violence against women made them both "change agents within the community"and "advocates for the communities." In the latter role, either on their own or on behalf of the community Mitanins pressured or negotiated with officials and institutions beyond health such as police.

SHRC also encouraged inter-sectoral linkages in Mitanins' work such as linking health issues with forest and indigenous people's rights. As Dost (2014, 222) notes, Mitanins' health work had synergy with theiractivism. Through one-on-one visits with families she cared for, a Mitanin gained trust and awareness about the different social needs of the community. She was then able to bring together communities with common concerns and mobilize them to take action. As we

describe below, Mitanins successfully connected health advocacy to other issues considered relevant by the community. Some observers report on the variable nature of the Mitanin work, within and beyond the health sector, and how it was contingent on local priorities (Nambiar and Sheikh 2016, 130; Nandi and Schneider 2014). As Dost (2014) also documents, Mitanins and their trainers helped prevent illiterate villagers from signing over their land to a private corporation. It was not until Mitanins arrived at a meeting organized by the private corporation that villagers were informed about the content of the document they were signing.

The SHRC always envisioned the Mitanin as a health activist who is expected to take a key leadership role in addition to her health education responsibilities. This means that Mitanins often operate outside the strict remit of health. The program's focus on social mobilization facilitated collective action by Mitanins in response to community needs: linking health to other sectors such as nutrition (Vir et al 2014; Kalita and Mondal 2012), child nutrition (Nambiar and Sheikh 2016), and forest rights (Nandi and Garg 2017). This focus beyond health suggests another instance of iteration in the program. The Mitanins' activities evolved over time: from child survival and essential care of newborn infants to rights-based activities that enable access to basic public services as fundamental entitlements to be secured through women's empowerment and community action (Sundararaman 2007). For example, Mitanins saw the struggle over forests as directly relevant to health.

In 2004, the *Adivasi Adhikar Samiti* (AAS or The Organization for Rights of Indigenous People) emerged out of a grassroots organization called the "Koriya Initiative" working on issues of rights of indigenous people with a focus on health and food security in the district of Koriya (Nandi and Garg 2017). The Mitanins "formed the backbone of this women-led organization, and provided leadership to it" (Nandi and Garg 2017, 389). The collective action by Mitanins in different blocks of Koriya, Sarguja, and Kawardha districts included resisting the state's Forest Development Corporation's attempts at deforestation. Mitanins along with members of AAS used a range of tactics such as right to information requests, building consensus among villagers, including panchayat members and members of Forest Protection Committees to gather signatures against felling operations, and organized *jan sunwais* or public hearings. Some even took 'solo direct action' like the Mitanin from Larkoda village who stopped a loaded truck from transporting logs (Nandi and Garg 2017, 393). Mitanins also set up community monitoring committees at the hamlet/village level to assess the functioning of panchayats and *gram sabhas* (village assemblies) (Garg 2006). It appears the initial approach to social mobilization—with a focus on publicizing the program and identifying Mitanins—evolved as Mitanins added new repertoires to their social mobilization and advocacy approach.

Activists from Koriya were also part of a documentation and dissemination initiative, the Public Health Resource Network (the Network). The Network works with Particularly Vulnerable Tribal Groups or PTG and their Mitanins to help them articulate their issues related to health and access to government services and plan accordingly (phrsindia.org). The Network in collaboration with SHRC undertook survey studies on accessibility to health and nutrition services by particularly vulnerable tribal groups. The findings from these studies were discussed in *sammelans* (public hearings). Mitanins, along with vulnerable tribal communities such as the Baigas, Pahari Korwas, and Kamars, discussed their findings and presented grievances to public officials. For instance, grievances related to the Kamar PTG included distance to childcare centers, lack of regular immunization, land ownership, training for farmers to improve agricultural productivity, and non-availability of irrigation.

To develop the Mitanins' community leadership role, the SHRC developed a multi-level program with personnel at the hamlet, village, block, district, and state levels. The choice of program unit was another specific innovation of the Mitanin Program. The SHRC recognized the existing constraints of physical geography in a state like Chhattisgarh where transport services are non-existent in remote rural areas. If they exist, they are disrupted during the monsoons (annual rainy season). Insufficient staff to population ratios, national government regulations on limiting number of sub-centers were other existing constraints that were considered. For these and other reasons of promoting community participation, linking health workers with local village councils or panchayats led SHRC to choose a hamlet (rural settlement smaller than a village, population size 250-500 population) as a unit of the program. This also allowed a Mitanin to reach socially vulnerable groups especially those based on caste that tend to inhabit different hamlets (Sundararaman 2003; Kalita and Mondal 2012).

According to a senior SHRC official, there is no pan-Mitanin organization in the state. There is a support structure that facilitates training and meetings with Mitanins. The support structure of the Mitanins included a trainer, block coordinators and panchayat level health coordinators. As Champa (2017, 44-45) notes, the block coordinator's "role is training and supervision,"and panchayat level health coordinators are "taught that they have no supervisory role, but are providing support to juniors, particularly for collective action on the social determinants of health." Panchayat level health coordinators invest a "third of their time in leading social accountability via Village Health Sanitation and Nutrition Committees (VHSNCs) in which trainers and Mitanins, together with the community, monitor twenty-nine indicators on government schemes for nutrition, education, employment, water, sanitation, and health (Champa 2017).". The "expected trajectory" of Mitanins was to become "Mitanin trainers and then gradually advance to other roles in the program (Nambiar and Sheikh 2016, 130)." According to one of the program founders: "As they [Mitanins] move up, space emerges for others. Otherwise, the program will stagnate (former SHRC leader, male, interviewed 20 January 2012, cited in Nambiar and Sheikh 2016, 130)."

Another forum for collective action by Mitanins were the meetings (*baithaks*) where Mitanin Program leaders at each level regularly meet with their seniors and juniors. These meetings have three main aims: mentoring juniors, ensuring their accountability, and collective problem-solving (Champa 2017). These meetings helped motivate Mitanins to do their work, promoted non-hierarchical relationships between Mitanins and their seniors, and helped to promote an esprit de corps (Dost 2014, 223). Another collective action forum that the SHRC supported are the annual *sammelans* (public hearings). In these sammelans villagers and state and panchayat officials interact and Mitanins present community grievances to officials. According to Mishra (2011), Mitanins:

> Displayed a lot of enthusiasm for such events…in places where they were better organized and had some catalytic support. Replication of Koriya experience of large mobilization events was encouraged specifically in 23 blocks in 9 districts where programme could find strong leadership at the block level. SHRC never funded these sammelans. The events required small expenditures…and it was raised locally through voluntary donations. Mitanins also bore their travel expenses to participate in these events.

According to Champa (2017, 69, 74-75), the sammelans resulted in greater power in the hands of Mitanins and the community, and "'visibly helped Mitanins as well as villagers to build their capabilities to assert themselves in front of powerful officials, and gain skills to organize such events independently in the future."

SHRC's holistic approach to health emerged organically but was also fueled by a threat to the program. In 2005, the health secretary changed and a less enthusiastic and allegedly 'corrupt' official was in charge; he viewed the SHRC as a hurdle in 'making money.'[17] The new government was not openly against the program but, in 2005, the EU funding was ending. The question of survival loomed large. For the SHRC, the program's survival necessitated its programmatic expansion beyond health.[18] Learning from the challenges of previous government-run community health programs, the Mitanin Program created an "integrated structure of human resources" (Kalita and Modal 2012). In 2006, "the Nutrition Security Innovation project, linked to the ongoing statewide Mitanin Program, was launched in twenty-three blocks of eleven districts for accelerating reduction of rate of undernutrition" (Vir et al 2014).

The Mitanin Program specifically emphasized integrating frontline workers of two government health and nutrition programs, and facilitating interaction and exchange between Mitanins and the Auxiliary Nurse and Midwife, the *Anganwadi* (rural mother and childcare center) worker. Mitanins were involved in "dialoguing informally with frontline workers" of the Integrated Child Development Services to "improve coverage of direct essential nutrition interventions with actions for promoting exclusive breastfeeding, hygiene feeding practices, full immunization, care of pregnant women, and providing support in improving access to subsidized food" through the Public Distribution System (Vir et al 2014, 88).

In addition to building synergies with Auxiliary Nurse and Midwife and *Anganwadi* workers, the Mitanin Program was inspired by earlier successful models of civil society-run programs. For example, experiments in one district led by a civil society program (the Koriya Initiative) demonstrated the successful achievements of Mitanins in organizing a community watch on nutrition programs through neighborhood communities. Engaging the leaders of the Koriya Initiative, the SHRC understood the importance of collectives, the strength of numbers, and the ability to stage visible protest and build alliances with other movements for social justice and legal aid. It initiated strategic partnerships with representatives from the state chapters of the Right to Food Campaign and People's Health Movement to integrate health and nutrition programming in the state. Due to the wide reach of these movements, the process of integration received a rights-based perspective. The two movements also helped with awareness generation. This in turn resulted in greater demand for services, monitoring of programs, and accountability of public functionaries to the people (Kalita and Modal 2012).

Support for collective bargaining by Mitanins

The second opening from above that produced changes in the Mitanin Program was the launch of the National Rural Health Mission (NRHM) in 2007: a national program to decentralize health care delivery. A key figure of the NRHM (later renamed the National Health Mission) is the accredited social health activist (ASHA). Mitanins are considered the precursor to ASHAs (Champa 2017). From its inception, Mitanins did not get regular renumeration. The initial program design allowed for the compensation to be determined by the community and the Mitanin (SHRC 2003). Another suggestion was allocating land for cultivation to the Mitanin's family through the local village council. Residents of each hamlet could choose to pay the Mitanin in kind (such as food grains) or in cash. As Nandi and Schneider (2014) note, in spite of small incentives, for the Mitanins, social recognition was the primary reward. Mitanins reported being happy meeting other women, people recognizing them, learning new things, and being honored by village elites.

However, with the NRHM, the focus on volunteerism[19] transitioned into a task-based incentive system. This meant Mitanins received cash payments from the state health department for fulfilling allotted tasks (Garg and Pande 2018). As paid line workers for the state health department, Mitanins were obligated to bring more people to utilize a narrow range of services (like immunization and maternal care). For example, Mitanins were tasked with promoting institutional deliveries for pregnant women. One study shows that the introduction of task-based incentives produced contestation amongst Auxiliary Nurse and Midwifes and Mitanins (Som 2016). Another evaluation of the program shows that some Mitanins expressed demands for fixed payments or higher incentives (Mishra 2011). According to an SHRC collaborator, Mitanins also demanded regular labor privileges: "In many places, Mitanin Sangathans or unions are emerging with demands for their own rights—payment, role as permanent workers (SHRC collaborator, male, interviewed 9 February 2012, cited in Nambiar and Sheikh, 130)."

With the inception of the ASAH program, the SHRC recognized the need for compensation. As Nambiar and Sheikh (2016, 130) note, "consciousness of broader contexts of political exclusion of women shaped the SHRC leadership's visible attentiveness to issues of professional mobility for the women who worked as Mitanins." Although, the agency did not persuade the government to fix a compensation package,they also did not prevent Mitanins protesting chronic delays in payments and demanding better payments, though Mitanins ensured their collective bargaining efforts did not damage their relations with their communities. For example, they chose not to go on strike or stop work (Garg and Pande 2018, 13).

Another way the SHRC was able to support Mitanins' role as community leaders and health rights activists was by leveraging NRHM's dual focus on incentives and community empowerment (Garg and Pande 2018). The NRHM's design emphasized the formation of participatory bodies like the Village Health, Sanitation and Nutrition Committees at the village level, creating space for community action on social determinants of health. The VHNSC is part of the local self-governance structure of panchayats. The purpose of VHNSCs is to build and maintain accountability mechanisms for community-level health and nutrition services provided by the government. Mitanins shared leadership of VHNSC with an elected panchayat representative. At all stages of the program the SHRC consciously emphasized the involvement of village councils (Nandi and Schneider 2014).

As Garg and Pande (2018, 10) describe, "Mitanins provide leadership in utilizing VHSNCs as accountability spaces, enabling communities to monitor local public services and organize local collective action to demand improvements". Services covered include food security, social security for the vulnerable, drinking water, and healthcare (Champa 2017;Nandi and Schneider 2014). Mitanins together with VHNSC members participated in a new convergence scheme called the "Swasth Panchayat" (Healthy Village) bringing together Mitanin action on nutrition security and VHNSC action on social determinants of health (Garg 2017).

Under this scheme the VHNSC began to monitor key issues related to access to health services such as immunization, free drug provision, referral transport, status of health of villagers particularly focused on common causes of infant and maternal mortality, and access to underlying determinants of health such as food, water, sanitation, and education. "When village level action was not enough to address service gaps, Mitanins joined other VHSNC members in planning meetings to bring together clusters of ten to twenty villages; these actions were further aggregated at block level with support of the SHRC and prioritized inter-sectoral accountability action on public services such as availability and access to water, food, and employment" (Garg and

Pande 2018, 10). This elicited enthusiastic responses from the community and became the "main agenda for collective action (Garg and Pande 2018, 12)."

We discussed earlier the leadership role of Mitanins in the forest rights struggle (Nandi and Garg 2017), thus, despite the introduction of cash-based incentives, they continued to play a critical role as advocates for the community collectively responding to community needs beyond healthcare. Arshima (2017, 36) describes Mitanins' actions—individual or collective—related to service provision or social accountability. For example, they wrote letters to state authority as a 'collective' when requesting new handpumps, raising money for a sick villager, reporting staff misbehavior, organizing a protest for unionization to demand an increase in Mitanin/ASHA wages[20], or protesting to reclaim a right to forest. In other instances, they reached out directly to state officials in their individual capacity such as disciplining a teacher for school absenteeism or to make a complaint against a corrupt official (Arshima 2017).

The SHRC also introduced a number of non-financial benefits to address the career aspirations of Mitanins such as training in Auxiliary Midwife and nursing schools or educational support for their children. Though "numerous Mitanins indicated these opportunities were too competitive for them or did not address their needs or demands (Nambiar and Sheikh 2016, 130)."The dilemma of CHW compensation is a real concern, especially because globally more women constitute the growing informal workforce in the health sector. An essential ongoing debate in the evolution of the Mitanin Program is who pays the Mitanin, how much, and in what form. The introduction of cash- task-based incentives signifies yet another cycle of iteration in the evolution of the program. However, task-based incentives, unlike fixed monthly payments, prevented higher officials exercising greater influence over Mitanins (Garg and Pande 2018). With support from the SHRC, the Mitanins were better prepared to set a wider agenda instead of being constrained by the agenda driven by cash incentives from the government (Garg and Pande 2018).

Conclusion

This case study documents the role of state and societal actors to institute a community health worker program, the Mitanin Program. Pro-reform actors in state and civil society developed the Mitanin Program to organize women from marginalized groups to secure their rights, most directly to healthcare. From its inception, reformists within the government worked to ensure a broad reach of the program and the participation of socially excluded groups.

The program created sustainable institutions such as the State Health Resource Center, granting it sufficient flexibility to help the program evolve over time, adapt to new policy changes, and maintain a movement-oriented approach to community health work. Much of this was made possible by prior openings from above such as the creation of a new state and the presence of pro-reform actors. Key reformists with prior experience within government and mass social movements also developed a preemptive strategy to institute the Mitanin Program and allowed it to adapt and grow (Garg and Pande 2018).

After initial funding from international agencies such as the European Union as well as international non-government organizations such as ActionAid India, the program was insulated from external shocks from changing funding agency agendas as well as electoral changes. The program was aggressively expanded at scale from the beginning, making it less vulnerable to elections or party politics. Unlike its predecessors, the Mitanin Program was also integrated with maternal care and child nutrition frontline workers to create a support structure for Mitanins and expand focus beyond health, and on social determinants of health such as food security , child nutrition, and water.

Strategic partnerships were also promoted between Mitanins and mass-based movements. Lessons were drawn from past experiences of mass movements, and alliances forged with existing ones such as the national Right to Food campaign and the People's Health Movement, to inform the Mitanins' holistic approach to health work. They have also forged new partnerships at the intersection of citizen science, women's rights, and community health workers to address the public health impacts of toxic air (Carbon Copy 2021). These partnershipsnew and oldbolster Mitanins' capacity to deliver responsive and equitable health services.

In addition to health, efforts were made to enable collective action among the Mitanins themselves. Where Mitanins were better organized and connected to grassroots organizations, the SHRC supported spaces for them to come together at scale. For example, sammelans (gatherings) became such informal spaces contributing to Mitanins' capacity and voice to offset the power of local health bureaucracy and elected elites. Strikes were supported because of Mitanins' conscientious efforts to prevent disruption of work while protesting payment delays or demanding better pay. With the help of SHRC, the program promoted collective bargaining powers to strengthen the Mitanins' position in labor and/or public health system negotiations. During the Covid-19 pandemic Mitanins reported receiving positive recognition from the state health department for their work on contact tracing, disease surveillance, monitoring the arrival of migrant workers from urban areas, and motivating people to get vaccinated.[21]

While most Mitanins started as volunteers, they eventually received some monetary compensation from the state health department as the national policy on community health workers evolved. Though the national policy introduced incentivized tasks, the SHRC used other provisions of the same policy to maintain Mitanins' focus on community action on social determinants of health. Risks of backlash in the initial years were also managed with the help of pro-reform actors within the state whose connection in law enforcement and higher-level politicians and bureaucrats reduced the risks for collective action. Over the last two decades, with SHRC's stewardship, the Mitanin Program has attempted to intricately balance its emphasis on developing Mitanins as community leaders and anticipating (and to the extent possible mitigating) risks involved in rights claiming.

References

Carbon Copy. 2021. "Meet the Mitanin. Korba's New Air Pollution Warrior." *CarbonCopy*, January 11, 2021. https://carboncopy.info/meet-the-mitanin-korbas-new-air-pollution-warrior.

Dost, Arshima Champa. 2014. " Enabling Collective Action in State Programmes: The Case of Community Health Workers in India." Pp. 207-228 in *Modern Dilemmas: Understanding Collective Action in the 21st Century*. Germany: Verlag Stuttgart.

Dost, Arshima Champa. 2017. "Accountability from Village to State: Enabling Trustworthiness in India's Rural Health System." PhD Thesis. India Institute, Kings College London.

Dost, Arshima Champa. 2017. "Enabling Social Accountability: The Community Health Worker Programmes of Chhattisgarh and Jharkhand." Policy Report No.21. http://www.thehinducentre.com/publications/policy-report/article9694936.ece.

Garg, Samir and Suchi Pande. 2018. "Learning to Sustain Change: Mitanin Community Health Workers Promote Public Accountability in India." Accountability Research Center, Accountability Note 4. https://accountabilityresearch.org/wp-content/uploads/2018/08/AN4_-English_8-16-18.pdf.

Garg, Samir. 2017. "Chhattisgarh Swasth Panchayat Yojana: Convergent Community Action for Health and its Determinants in Rural India." Pp. 153-169 in *The Social Determinants of Health in India: Concepts, Processes, and Indicators*, edited by D. Nambiar and A. Muralidharan. Singapore: Springer Nature.

Gustafsson, Karin M. and Rolf Lidskog. 2018. "Boundary Organizations and Environmental Governance: Performance, Institutional Design, and Conceptual Development." Climate Risk Management 19: 1-11.

Hussain, Eisha. "Chhattisgarh Government is Taking Back Covid Incentives Paid to Mitanin." *Behan Box*, 17 November. https://behanbox.com/2021/11/17/chhattisgarh-government-is-taking-back-covid-incentives-paid-to-mitanins/.

Kalita, Anuska and Shinjini Mondal. 2012. "Role of Innovative Institutional Structures in Integrated Governance: A Case Study of Integrating Health and Nutrition Programs in Chhattisgarh, India." Journal of Health Organization and Management 26(6): 758-777.

Misra, J.P. 2011. "Evaluation of the Community Health Volunteer (Mitanin) Programme." European Union State Partnership Programme. http://health.cg.gov.in/ehealth/MitaninFinalReport11thMarch2011.pdf.

Nambiar, Devaki and Kabir Sheikh. 2016. "How a Technical Agency Helped Scale Up a Community Health Worker Program: An Exploratory Study in Chhattisgarh State, India." Health Systems & Reform 2(2): 123-134.

Nandi, Sulakshana and Samir Garg. 2017. "Indigenous Women's Struggles to Oppose State-Sponsored Deforestation in Chhattisgarh, India." Gender and Development 25(3): 387-403.

Nandi, Sulakshana and Helen Schneider. 2014. "Addressing the Social Determinants of Health: A Case Study from the Mitanin (Community Health Worker) Programme in India." Health Policy and Planning 29 Suppl 2: ii71-81.

Nandi, Sulakshana. 2012. The role of community health workers (CHW) in addressing social determinants of health in Chhattisgarh, India. Mini-thesis, Masters of Public Health, University of Western Cape.

Schaaf, Marta, Caitlin Warthin, Amy Manning, and Stepahnie Topp. 2018. "Report on the 'Think-in' on Community Health Worker Voice, Power, and Citizens' Right to Health." Accountability Research Center, Learning Exchange Report 3. http://accountabilityresearch.org/web/wp-content/uploads/2018/01/ Learning_Exchange_Report3_January-18-1.19.18.pdf.

Som, Mithun. 2016. "Volunteerism to Incentivisation: Changing Priorities of Mitanins Work in Chhatisgarh." *Indian Journal of Gender Studies* 23(1):26-42.

Sundararaman, Thiagarajan. 2007. "Community Health-Workers: Scaling Up Programmes." The Lancet 369(9579): 2058-2059.

SHRC. 2003. "Mitanin Programme: Conceptual Issues and Operational Guidelines." Raipur: State Health Resource Centre.

Tillin, Louise. 2013. *Remapping India: New States and Their Political Origins*. Hurst Publishers: London.

Vir, Sheila C., Anushka Kalita, Shinjini Mondal, and Richa Malik. 2014. "Impact of community based Mitanin programme on undernutrition in rural Chhattisgarh State, India." Food and Nutrition Bulletin 35(1):83-91. The Nevin Scrimshaw International Nutrition Foundation. https://journals.sagepub.com/doi/pdf/10.1177/156482651403500110.

Notes

1 A *Mitanin* in the local language means "friend." In the villages of Chhattisgarh, women and men often chose a "Mitanin" or a "Mitan." This is done ceremoniously. The relationship between two women continues throughout their life, even after marriage. By naming the program after a local tradition the government intended the Mitanin to be a "true guide" to the community in all their endeavors (Shukla 2003, 13).

2 According to the Government of India, forty percent of India's land area is affected, encompassing twenty of twenty-eight states, and 223 of 640 districts (cited in Shah 2019).

3 Adivasis constitute thirty-one point eight percent of the total population of the state (Census of India 2011).

4 Though 'thirty seven percent of the people—eleven million—are still MPI poor, and ninety-three% of these live in rural areas and five point one million are members of Scheduled Tribes' (OPHI 2020).

5 Senior Programme Coordinator, State Health Resource Centre, Chhattisgarh. Interview with author, 02.14.2020

6 Ibid.

7 Ibid.

8 The Government of India launched the first CHW program in 1977. Some small-scale programs were also initiated by non-government organizations. The prominent among them are the Comprehensive Rural Health Programme, Jamkhed; Society for Education, Welfare and Action (SEWA); Society for Education, Action, and Research in Community Health (SEARCH), Ghadchiroli; FRCH in Mandwa and others. The launch of the first CHW program was met with a "mixture of contempt and alarm…and ridiculed for allegedly promoting quackery" and closely identified with the Minister… attacks on the Minister became attacks on the CHW scheme itself' (Bose 1983, 39, 40). :According to the SHRC, the choice of women CHWs assumed that there was a "lesser tendency [in women] to settle down as quacks" (SHRC 2003, 20-21).

9 See Werner (1981) for a discussion of the role of CHWs where he asks CHW program architects to consider whether CHWs become 'lackeys' (working only on specific tasks assigned by the health bureaucracy) or 'liberators' (agents of social change who mobilize their communities).

10 Indira was the first name of the former Prime Minister Indira Gandhi, who was the mother-in-law of the leader of opposition who launched the Mitanin Program.

11 By which we mean, tangible initiatives by state actors to create space for societal action for pro-accountability institutional change.

12 Senior Programme Coordinator, State Health Resource Centre, Chhattisgarh. Interview with author, 02.14.2020.

13 For example, Harsh Mander, a civil servant with a track record for implementing pro-poor initiatives in the neighboring state of Madhya Pradesh was on deputation to ActionAid India. Mander approached the chief minister of Chhattisgarh to discuss a role for ActionAid in developing social sector policies and programs. A third influential person was a professor of medicine at a national research institute in Pondicherry, Dr. T. Sundararaman. With decades of experience with community health worker programs as well as social movements for social justice and literacy. Sundararaman became the key architect of the Mitanin Program.

He was brought on deputation to Chhattisgarh and together with Mander and Shukla undertook a study for the need for community health workers. Senior Programme Coordinator, State Health Resource Centre, Chhattisgarh. Interview with author, 02.14.2020.

14 Ibid

15 Ibid

16 These partners included Rupantar, Jan Swasthya Sahayog, Zilla Saksharta Samiti (Durg), Bharat Gyan Vigyan Samiti, Raigharh, and Ambikapur Health Society and Ramkrishan Mission (SHRC 2003, 39).

17 Senior Programme Coordinator, State Health Resource Centre, Chhattisgarh. Interview with author, 02.14.2020.

18 Ibid.

19 In the initial years, all *Mitanins* were unpaid volunteers, like in earlier programs. In 1977, CHWs were paid a modest compensation during training (two hundred rupees), which was reduced to fifty rupees, since they were expected to work only two to three hours a day. A year later, in response to CHW demands for higher wages the national government emphasized that 'CHWs were representatives of the people and social workers' (Bose 1983), not government employees. Efforts to unionize led to a 'curious administrative solution': renaming of the program to Community Health Volunteer Scheme (Bose 1983, 41).

20 Mitanins recently went on strike against a government order instructing Mitanins to return their Covid-19 incentives in spite of pending arrear payments for all their work to contain the spread of Covid-19 in the last two years (Hussain 2021).

21 Author exchange with SHRC official 27 September 2021.

www.accountabilityresearch.org

American University
School of International Service
4400 Massachusetts Ave NW
Washington, DC 20016
www.accountabilityresearch.org