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Suchi Pande

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Suchi Pande

ABSTRACT

Women community health workers from a government run programme in India have been uncommonly successful in combining rights-based advocacy (accountability to their communities) with (nominal) paid work on healthcare tasks by the state. Over two decades 70,000 indigenous women Mitanins or community health workers have advanced community health and gender rights of the broader communities they are part of, and their own labor rights. Being able to strategically advocate for both types of rights is an experience unmatched by their global counterparts. This Note focuses on two elements of the Mitanin pre-emptive learning strategy, the movement-building approach of a government run programme to empower frontline community health workers, and the role of a hybrid agency in prioritising social mobilisation by these workers to improve healthcare delivery.

ARTICLE HISTORY



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Introduction

Community Health Workers (CHWs) are often viewed as extension or link workers rather than as health rights advocates or community leaders (Schaaf et al. 2018). The evidence from a large-scale government-run CHW program in India suggests CHWs can combine rights-based advocacy (accountability to their communities) with (nominal) paid work, while advocating for themselves to have better working conditions, payment, and to ensure COVID-19-related compensation. Under the Mitanin program, over 70,000 women CHWs have reached 26 million people across the state of Chhattisgarh. In their role as CHWs, and community leaders, and activists, the Mitanins – most of whom are Adivasi (Indigenous) and Dalit women – are supported by the State Health Resource Centre (SHRC), a hybrid organisation which includes civil society, health professionals, and government officials, and serves as a bridge between Mitanins and the health system. SHRC provides technical assistance to the health department while simultaneously imbuing the program and its participants with movement sensibilities that go beyond the institutional mission of healthcare delivery. Over time, Mitanins have developed sufficient autonomy for collective action in areas outside of their official health work. For this work they rely on a vertically integrated support network of fellow Mitanin trainers and supervisors, and SHRC staff.

Over the last two decades, the Mitanin CHWs of Chhattisgarh have been uncommonly successful in combining rights-based advocacy with work on healthcare tasks nominally paid for by the state. At

CONTACT Suchi Pande  pande@american.edu  Accountability Research Centre, School of International Service, American University, Washington DC, USA

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the program level, Mitanins bridge the health system and community, and they have achieved social recognition in their communities and acquired sufficient clout vis-à-vis the state health bureaucracy to negotiate better services. They have also developed an inter-sectoral approach to health rights that includes advocacy on food security (access to government supported food programs) and gender-based violence, as well as health system responsiveness. For example, preliminary findings from survey and interview data of Mitanins across the state of Chhattisgarh shows that in addition to providing information to villagers on food security entitlements and gender-based violence, Mitanins are engaged in identifying and monitoring gaps in these areas and more importantly, they are collectively or individually taking up the issues with panchayats (village local councils) or with local civil servants with uncommonly high-resolution rates. At the policy level, Mitanins have helped inspire a national CHW program, the Accredited Social Health Activist (ASHA) program, which has resulted in nearly one million trained CHWs (Nandi and Schneider 2014). They are also engaged in collective action for two types of accountability claims – more recently, COVID-19 compensation related, and for better work conditions and pay – and have managed to do so without threats of dismissal or reprisal.

This Practice Note will briefly trace the evolution of the Mitanin CHW program and its continued adaptation and growth, to draw attention to two elements of its pre-emptive learning strategy: a movement-building approach that views Mitanins as activists rather than as link workers, and the role of a hybrid agency in implementing and adapting this learning strategy.

Methodology and research objective

The note includes evidence from a review of secondary literature on the Mitanin program, the author's ongoing engagement with key informants in the SHRC since 2017, as well as preliminary results from interview/focus group findings undertaken during a collaborative action-learning project (2021–2022). The objective of the action-learning project, led by the Accountability Research Centre in collaboration with the SHRC, was to explore and document the Mitanins' strategies and tactics in response to significant challenges in their social struggles. These challenges include threats from changes in government and funding shortages, combining and sustaining multi-issue advocacy, negotiating better pay and working conditions, difficulty in delivery of basic health-care services due to the COVID-19 pandemic, and the high personal risk and lack of adequate compensation as COVID-19 first responders for rural and remote populations.

Learning to sustain change: the pre-emptive strategy of the Mitanin program

Mitanin is a government-run community health worker program launched in 2002 in one of the poorest central Indian states, Chhattisgarh. It was India's first attempt at "state-initiated community activism" with an all-women workforce promoting collective action to support community demands for entitlements from the state (Dost 2014, 209). The program was rapidly expanded and implemented at scale within the first two years, to prevent rollback and as a survival tactic. The number of CHWs selected increased from 6,000 to 30,000 within the first year (2002), and to 54,000 the following year (Sundaraman 2007). The program is currently implemented through a structure of supervisors and facilitators, former Mitanins who have been promoted. The SHRC oversees the implementation of the program and coordinates a multi-level support network of supervisors and trainers who select, train, and mentor over 70,000 Mitanins across the state (see Champa 2017 and Nandi and Schneider 2014 for detailed descriptions of the structure).

Community health worker programs worldwide face challenges in achieving accountability to people they are intended to serve. CHWs face tensions between upward accountability towards health officials as employees, and downwards to the public who access and use health services (Schaaf et al. 2018). Over time, the Mitanin program has developed a proactive strategy that enables Mitanins to undertake multi-issue advocacy beyond healthcare and enable sustained

action on public accountability (Garg and Pande 2018). Many of the actions of Mitanins can be viewed as what Fox (2015) calls “strategic approaches” to accountability: multiple, coordinated tactics that simultaneously involve iterative cycles of monitoring and advocacy, covering broad geographic areas and social inclusion.

A key proposition is that the Mitanin CHW program uses a pre-emptive learning strategy, supported by SHRC that helps the program adapt to policy and government changes, while simultaneously prioritising social mobilisation by Mitanins to improve healthcare. This strategy has evolved over time and over the last two decades, enabled Mitanins to combine rights-based advocacy (accountability to their communities) with (nominal) paid work on healthcare tasks by the state. This strategy was in part made possible by a political opening in 2000, the creation of the state of Chhattisgarh, which triggered a reformist bureaucrat in the health department to provide financial, technical, and social support to organise Indigenous (Adivasi) women to secure their rights to healthcare (Pande 2022). This means that the Mitanin program, from inception, adopted a proactive, movement-building approach to public health, and thus avoided becoming a narrow technocratic intervention. Here, we focus on two elements of the strategy: the uncommon design of the Mitanins role and its evolving focus on multi-issue activism, and the role of the hybrid agency, SHRC.

Mitanins as service providers and change agents

The activist approach of the Mitanin program included building political capacities of marginalised women by envisioning them as change agents within the community and not simply as link or extension workers. The Mitanins started out as volunteers and not paid government employees, thus they were partially insulated from the power relations of the health system. The community decided the Mitanins’ compensation, with villagers choosing to pay in-kind (such as food grains) or in cash. The process of selecting Mitanins was also intentionally designed to be partially embedded within the community, to anticipate pushback from, and capture by, local elites.

From 2007, Mitanins started earning task-based cash incentives aligned with the national ASHA program. This posed a conflict with the original mandate of the program to ensure Mitanins operated with relative autonomy from local elites and health bureaucracy. Together with the SHRC, the Mitanins were able to overcome the conflict by leveraging the community empowerment language in the ASHA program to utilise participatory spaces at the village level to continue to advocate for community rights to food, employment, and forest rights (Garg and Pande 2018). For instance, Mitanins occupy leadership positions in local committees such as the Village Health and Sanitation Committees, utilising them as accountability spaces, enabling communities to monitor local public services and organise local collective action to demand improvements such as immunisation, free drug provision, referral transport, and information on the health status of villagers, particularly focused on common causes of infant and maternal mortality, and villagers’ access to underlying determinants of health such as food, water, sanitation, and education (Garg and Pande 2018).

When these spaces seem inadequate to ensure government responsiveness, the Mitanins have escalated issues to higher levels. Supported by a network of trainers and supervisors mentioned above, they have raised issues that do not receive government response at the local level in state-wide public dialogue forums such as *jan samwaads*. They have also engaged in direct action through protest rallies and marches to petition health officials. As Champa (2017, 26) notes, in some instances, Mitanins have engaged government agencies/officials as a “collective” – for example, when requesting new handpumps, raising money for a sick villager, reporting staff misbehaviour, organising a protest for unionisation to demand an increase in wages, or protesting to reclaim a right to forest. In other instances, they have 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. Another accountability space Mitanins utilise is their annual gatherings or *sammelans*. These *sammelans* have “visibly helped Mitanins as well as villagers to build their capabilities to assert themselves in front of powerful officials and gain skills to organise such events

independently in the future” (Champa 2017, 69, 74–75) and resulted in greater power in the hands of Mitanins and the broader publics they serve.

Role of the hybrid agency

The creation of the SHRC was an innovation adopted by the Mitanin program at its inception (Nambiar and Sheikh 2016). According to one of the program’s architects, a cornerstone of its pre-emptive survival strategy was forging state–civil society partnerships, to address common challenges such as an unclear relationship between the CHW program and the public health system. The creation of such a hybrid agency had not been part of previous government-run CHW programs; in the case of the Mitanin program, it was justified and made possible by the creation of the new state of Chhattisgarh and a resulting leadership void (Nambiar and Sheikh 2016; Pande 2022).

The SHRC was created to facilitate the participation of actors from both government and civil society, while simultaneously providing technical capacity and inputs to the program. SHRC supported multi-issue activism by Mitanins because it envisioned them in key leadership roles, rather than in a narrow link worker role. Over time, the SHRC helped build Mitanins capabilities for collective action, linking health to nutrition, child nutrition, forest rights, and violence against women (Garg and Pande 2018).

SHRC was also mindful of institutional limitations and the constraints of physical geography. In response it developed a multi-level program with personnel at the hamlet (a rural settlement smaller than a village, population size: 250–500), village, block, district, and state levels. Promoting community participation, linking health workers with local village councils or panchayats, the SHRC chose the hamlet as a unit of the program. This allowed Mitanins to reach socially vulnerable groups, especially those based on caste that tend to inhabit different hamlets.

Through government guidelines and training, over the years, the SHRC institutionalised the multiple roles of Mitanins – as service providers, agents of public accountability, and a link with government healthcare services by facilitating their multi-issue activism – emphasising the link between rights to healthcare and to clean water, the environment, and nutrition, as well as questions of gender, livelihoods, and social support. SHRC played a vital role in responding to and facilitating Mitanins’ evolving social mobilisation and collective action in response to needs of local villagers, while simultaneously assessing waning government support for the program. Holistic approach to healthcare aside, in 2015 the program’s survival was at stake and SHRC adapted quickly, reading the political sentiments to expand the program beyond health. In 2006, a new project focused on nutrition security was launched and linked to the state-wide Mitanin program for accelerating the reduction of undernutrition across the state. The Mitanin program specifically emphasised integrating the frontline workers of two government health and nutrition programs, and facilitating interaction and exchange between Mitanins and the auxiliary nurses and midwives who were based in *anganwadi* (rural mother and childcare centres) (Garg and Pande 2018).

The SHRC also supported Mitanins’ labour rights activism. In many countries, especially in the Global South, CHWs tend to be underpaid and overworked. During the pandemic, the plight of India’s overburdened CHWs was captured in the concept of “care extraction” (Wichterich 2021) with several national protests by ASHAs demanding compensation for participation in the government’s crisis response. Mitanins also protested to secure their COVID-19-related compensation. Although Mitanins primarily began as volunteers, they engaged in labour rights activism for better pay and working conditions even before the introduction of task-based incentives under the ASHA program or the more recent COVID-19-related compensation protests. The SHRC recognised the need for compensation. Although the agency did not persuade the Chhattisgarh State Government to fix a compensation package, they also did not prevent Mitanins protesting chronic delays in payments and demanding better payments. The Mitanins organised two strikes (in 2016 and 2022) on two types of accountability claims (better work conditions and pay and COVID-19-related compensation) and they were successful in that they engaged in autonomous mass action and did not face backlash. This experience is

unmatched by their global counterparts since it avoided alienating the health department while simultaneously permitting Mitanins to carve out autonomy to fight for their labour rights and for compensation for undertaking high-risk COVID-19 mitigation efforts.

The dilemma of CHW compensation is a real concern, especially because, globally, more women work in the health and social care sector in often low paid jobs. An essential ongoing debate in the evolution of the Mitanin program is who pays the Mitanins, how much, and in what form. However, the task-based incentives introduced by the ASHA program, unlike fixed monthly payments, prevented higher officials exercising influence over Mitanins (Garg and Pande 2018). With support from the SHRC, the Mitanins were better prepared to set a wider agenda aligned with community needs instead of being constrained by the agenda driven by cash incentives from the government.

Conclusion

Over two decades, SHRC has trained and supported Mitanins in their roles as health workers, and in their broad-based accountability work on denial of rights and gender-based violence, as well as their own labour rights. This is in part due to the program's explicit view of Mitanins as activists rather than as link workers. In the past 21 years Mitanins have worked as frontline defenders of their communities, advocating for socio-economic rights beyond healthcare. A focus on social determinates of health is considered important for improving health and reducing long-term disparities in health and health care (Nandi and Schneider 2014). In addition to the health responsibilities that the state health bureaucracy assigns (immunisation, outreach, and awareness), Mitanins have engaged in strikes (across the state of Chhattisgarh) establishing high degree of public legitimacy and job stability. Thus, advancing their own labour rights and advancing community health and gender rights of the broader communities they are part of. Being able to strategically advocate for both types of rights is an experience unmatched by their global counterparts. These gains need to be viewed in relation to an explicit program design and vision of marginalised women as community leaders in addition to health workers. That Mitanins have gained political clout vis-à-vis local elites and are able to undertake collective action on behalf of their communities and for themselves is remarkable and in partial fulfilment of the stated aim of the Mitanin program.

Disclosure statement

No potential conflict of interest was reported by the authors.

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