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Community Health Workers as Rights Defenders: Exploring the Collective Identity of the Mitanins of Chhattisgarh, India

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Cover photo: Mitanins attending a rally to raise awareness of gender-based violence in Kawardha, marching behind a banner reading 'A campaign to stop violence against women.' Gender-based violence is a punishable offence under Indian Penal Code 223, 304 and 376.

Photo credit: © Rupesh Yadav

Contents

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About the Authors

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Samir Garg is a researcher and practitioner. His work has been focused on strengthening health systems and food security programs, including as an adviser to Supreme Court Commissioners on the right to food in India. He worked for the State Health Resource Centre in Chhattisgarh and engaged with the Mitanin program for almost 20 years. He has a PhD in health systems management. His areas of interest are community participation, primary health care, and management of public systems.

Summary

This Working Paper discusses the Mitanin program, a state-run community health worker program in Chhattisgarh state, India. It is based on a year-long reflection and action research exercise by the implementing organization, the State Health Resource Centre (SHRC).

We argue that the collective identity of these community health workers (Mitanins) is central to their work defending the social and economic rights of their community. Collective identity often plays an important role in social movements for people's economic and political rights. However, government-funded workers rarely get involved in such movements. The authors wanted to understand whether collective identity plays a role in driving the multi-issue activism of community health workers.

A composite definition of this collective identity emerged from the research. Throughout the interviews and discussions, the Mitanins described their collective identity as a sense of solidarity that all Mitanins share with the community they serve and belong to, and a feeling of sisterhood with other women and each other. It is the shared experience of being a group of empowered women with a common mission who must use their knowledge and compassion to support the people they serve. The value system underpinning their mission dictates that people should not be denied their rights.

We found that the Mitanins' collective identity is layered; they are not merely frontline health workers, but women who care deeply about their community. They are problem-solvers, activists, and community leaders. Their collective action and collective identity as women leaders in solidarity with the community is mutually reinforcing, and has enabled them to undertake multi-issue activism and transform themselves into frontline rights defenders.

We conducted a state-wide survey along with focus group discussions and in-depth interviews. The survey (n=558) aimed to establish what proportion of Mitanins are involved in multi-issue activism. It found that in the preceding three years, 84 percent had taken rights-based action in at least one of three domains: food security and nutrition (68 percent); healthcare (56 percent); and gender-based violence (21 percent). We refer to these actions as 'rights-based' because they involve negotiation and confrontation with local elites and government officials, as well as writing formal complaints to government officials. Other than rights-based actions, Mitanins also provide information to community members about their rights and entitlements to health programs, food security, and nutrition under government programs—information that is often not readily accessible to poor people in India.

This paper analyzes the patterns of autonomous collective action through discussion, interviews, and the rights-based songs and slogans written by Mitanins. The authors argue that the Mitanins' collective identity was formed due to two main factors: the program's movement-building approach; and the degree of autonomy enjoyed by Mitanins. The movement-building approach nurtured the activist tendencies of Mitanins, and the voluntary nature of their work allowed them to retain their autonomy vis-à-vis the health system bureaucracy.

1. Introduction

This Working Paper focuses on the collective identity of state-funded community health workers (known as Mitanins) in Chhattisgarh state, India. We discuss why Mitanins go beyond the requirements of their role and engage in multi-issue activism to uphold the rights of their communities. It is unusual to see state-funded actors mobilizing around the denial of people's social, political, and economic rights, or taking action to defend those rights; Mitanins are thus an exception to the norm. Often, the collective identity of actors is at the center of such mobilizations, as part of social movements (Fominaya 2010). In this Working Paper, we explore whether collective identity plays a role in driving the multi-issue activism of state-funded actors such as the Mitanins.

Drawing on multi-method, qualitative action research,[1] and existing literature on collective identity in social movements, we explored three questions: What is the collective identity of Mitanins? Did this play a critical role in the social movement started by the Mitanins? And does that collective identity translate into collective action?

The Mitanin ('female friend') program has been implemented by a unique parastatal agency focused on health reforms, the State Health Resource Centre (SHRC). The agency was established in 2001 against a backdrop of health reforms. SHRC adopted a movement-building approach to implementation. The organization envisioned that Mitanins would be more than just a link for their community to the health system; they would also become community leaders and activists. Women from rural villages—many of whom belonged to marginalized groups such as Scheduled Castes, Scheduled Tribes, and Other Backward Classes—were selected and trained to provide health services but also encouraged to take up other issues on behalf of their community.

More than 20 years after the program began, this Working Paper reports on new research by SHRC, which found that the Mitanins' collective identity motivates them to work not only on health rights, but also food security and nutrition, and gender-based violence. This collective identity is layered; Mitanins are not only frontline health workers in a government-run program, but also women who care deeply about their community. They are problem-solvers (because they address the challenges facing people in their community), and activists (because they work to uphold people's rights). They share a strong bond with their fellow Mitanins, linked both to their common mission to serve, and their identity as women.

Our survey gathered data on the activities undertaken by 558 Mitanins over the past three years. Findings indicate that most had taken action beyond the requirements of their role, and provided information on food security and nutrition under government programs to community members, which we refer to as 'rights-based action'. This term describes work such as negotiation and confrontation with local elites and government officials, writing formal complaints to government officials, reaching out to *panchayats* (elected village councils),[2] and registering police complaints (on behalf of survivors) in cases of gender-based violence. Of the Mitanins surveyed, 56 percent had taken this kind of extended action on health rights, 68 percent on food security and nutrition, and 21 percent on gender-based violence.

The Mitanins' collective action for rights, and their collective identity as women leaders in solidarity with the communities they serve and belong to, are mutually reinforcing. Their experience shows that state-funded actors, enabled by 'movement sensibilities', can engage in activism for their communities when driven by their collective identity. We define movement sensibilities as when actors in a social movement are driven by a shared mission, or a common cause (Horn 2013), due to inequality or unmet political, social, and economic needs (Horn 2013; Millward and Takhar 2019; Nardini et al. 2021). Mitanins are enabled by these movement sensibilities and driven by their collective identity, which has allowed them to undertake multi-issue activism and transform themselves into frontline rights defenders.

2. Context and Evolution of the Mitanin Program

2.1 Context: The social determinants of health in Chhattisgarh

In 2000, the Indian state of Chhattisgarh bifurcated from neighboring Madhya Pradesh, with the most underdeveloped areas forming part of the new state. In 2019, 41 percent of the state was forest cover (Forest Survey of India 2019). According to the 2011 national census, just over two-thirds (76.7 percent) of the population of Chhattisgarh live in rural areas, while the remainder in urban areas (Registrar General of India 2011a). Official estimates from 2011–12 show that 44.6 percent of the state's rural population and 24.7 percent of the urban population live below the poverty line—that is, they earn less than US$4 per month in rural areas, and less than US$6 per month in urban areas (Reserve Bank of India 2012). In 2011, 31 percent of the state's population belonged to Scheduled Tribes (Registrar General of India 2011b)—the seventh largest such population of any Indian state (Chandramouli 2013)—while Scheduled Castes constituted 13 percent of the state's population (Registrar General of India 2011c). According to an unpublished report of the Quantifiable Data Commission, in 2022 Other Backward Classes constituted 41 percent of the population (Baghel 2023). Primarily agrarian rural areas of Chhattisgarh are divided along caste lines, with people belonging to Scheduled Castes and Scheduled Tribes at the bottom of the hierarchy. However, rural Chhattisgarh has a history of anti-caste movements, which have repeatedly challenged the hegemony of 'upper castes' or 'dominant caste' groups (Singh 2013).

Chhattisgarh has a mixed health system including an extensive network of public facilities from village to state level, which coexists with an unregulated private health sector (World Health Organization 2022). This mixed system is mired with inequity in access to and utilization of services, often along the lines of socioeconomic status, caste, disability, and gender (Nandi et al. 2017; Nandi, Schneider, and Garg 2018; Sen 2016). The state's public health system has weak infrastructure, a shortage of doctors and nurses, and a dearth of diagnostic services (National Health Mission 2022). The government provides health services through a network of health centers and hospitals that are distributed on the basis of population need. However, health centers are not always accessible to people living in villages, and transport facilities can be erratic (Sen 2016). The private health sector, on the other hand, is largely concentrated in urban areas and is far from affordable for many people (Garg, Bebarta, and Tripathi 2020; Mackintosh et al. 2016; Nandi et al. 2016). A study conducted in Chhattisgarh found that the cost of hospitalization for treatment of Covid-19 in a private hospital was 35 times higher than that in a public facility (Garg, Bebarta, Tripathi, and Krishnendu 2022). The study showed that the lack of proper regulations and poor implementation of existing regulations has allowed overcharging in the private sector. The state has a long history with publicly funded insurance schemes, but evidence shows that these have failed to protect vulnerable people from catastrophic illness-related expenditure in private hospitals (Garg, Bebarta, Tripathi, and Krishnendu 2022; Nandi 2020).

The maternal mortality ratio in Chhattisgarh was 137 per 100,000 live births—one of the highest rates in India (Registrar General of India 2022). The National Family Health Survey (NFHS-5) of 2020–2021 showed that the infant mortality rate in Chhattisgarh was 44.3 per 1,000 live births; only 9.8 percent of children born at home received care in a health facility within 24 hours of birth, and less than two-thirds (60.1 percent) of pregnant women received 4 ante-natal care visits (Ministry of Health and Family Welfare 2021). Women in government hospitals are often subjected to ill-treatment, including obstetric violence (defined by O'Brien and Rich (2022) as harm inflicted during pregnancy, childbearing, or the post-partum period), and deaths due to medical negligence have also been reported (Nidhi 2020). People with disabilities are also mistreated and discriminated against in the public sector, and are often denied access to healthcare services they are entitled to, either due to accessibility issues or as a result of apathy (State Health Resource Centre 2021).

In India, one of the most important social determinants of health is food and nutrition. Chhattisgarh state has one of the highest levels of malnutrition in the country: 34.6 percent of children under 5 years are stunted (height-for-age) and 23.1 percent of women have a below normal body mass index (<18.5 kg/m^2). There are also high levels of anemia among women aged 15–49 years (61 percent) and children under 5 years (67.2 percent) (Ministry of Health and Family Welfare 2021).

One of the major government programs addressing food security and hunger in Chhattisgarh is the Public Distribution System (PDS). The state is known for its 'Food for All' model under the National Food Security Act (2013) and the Chhattisgarh Food Security Act (2012). The PDS protects millions of people from hunger and food insecurity, particularly the poorest people in society (Drèze 2019). Seventy-nine percent of the state population have been identified as poor, and require food security support from the government (Department of Food and Public Distribution 2023). Grain is provided through a network of government-regulated 'Fair Price Shops,' also known as ration shops, which provide subsidized rice, sugar, salt, and kerosene oil. These shops are run by Self-Help Groups, cooperative societies, *van suraksha samitis* (Forest Protection Committees), and *panchayats*. The PDS has a grievance redress mechanism that people can use to raise any problems, but the system is still prone to exclusion errors, corruption (theft and adulteration of grain), and other practices that lead to denial of entitlements (Drèze 2019).

NFHS data from 2019 show that 19 percent of women in Chhattisgarh had experienced physical or sexual violence and 4 percent had experienced both; 20.9 percent of married women said that they had experienced gender-based violence (Ministry of Health and Family Welfare 2021). In 2019, a national survey showed that in Chhattisgarh, 57.2 percent of men (aged 10–75) consumed alcohol (Ambekar et al. 2019), and many studies have shown a link between alcohol use and gender-based violence (Pitpitan et al. 2013; Swahn et al. 2021). Only two percent of survivors of gender-based violence in India seek access healthcare services, although they experience long-term physical consequences and deep psychological distress (Médecins Sans Frontières 2022). In Chhattisgarh, women belonging to marginalized sections of society are more vulnerable to gender-based and caste-based violence. Given the taboos and patriarchal norms surrounding gender-based violence, incidents are often not reported, which means that the actual extent of the problem remains underestimated (Gupta 2014).

2.2 Background to the Mitanin program

The Mitanin program was initiated at a crucial political juncture, just after the bifurcation of Chhattisgarh from Madhya Pradesh. The newly elected government introduced some major health sector reforms, including the roll-out of the Mitanin program to rural areas in 2002.

The program has been operationalized under the stewardship of the SHRC, a parastatal agency that includes members of government and civil society. SHRC has also been described as a 'boundary organization' as it works at the interface of state and society (Gustafsson and Lidskog 2018). The combination of the creation of Chhattisgarh, and the reformist government, meant that a policy window opened that enabled appropriate political and bureaucratic support for a boundary organization like SHRC and a rights-based health initiative like the Mitanin program (Garg and Pande 2018; Wangel 2011).

SHRC developed the Mitanin program with funding from the Chhattisgarh state government and some international partners. As 'female friends', Mitanins were always intended to be more than community health workers. Rather than being restricted to undertaking narrow, specific health-related tasks, their role was envisioned as involving rights-based activities related to the social determinants of health (Commission on Social Determinants of Health 2008).

Under the Mitanin program, there are 72,048 women community health workers, who reach around 24 million people across 20,000 villages and 20 major cities. Mitanins provide healthcare services and health education to communities and link them with government services. Each Mitanin serves around 200 to 300 people. Multiple

representative studies have shown that almost 50 percent of Mitanins come from Scheduled Tribes and Scheduled Castes, and around 44 percent belong to Other Backward Classes (Garg, Dewangan, et al. 2022; Tata Institute of Social Sciences and Department of Health and Family Welfare Chhattisgarh 2015).

Mitanins were selected through a process that was built on the cultural and social sensibilities of their local community, deliberately avoiding a technocratic approach (State Health Resource Centre 2003). Initially, the selection strategy was to identify women who were already socially active in their village, who were referred to as "women who cared about the people" and showed some leadership qualities. The selection process was managed by non-government facilitators from within the communities the Mitanins would serve, recruited by the SHRC team. These facilitators were aware of the cultural and social dynamics of each community, and sought support from other community members to choose a Mitanin from their village. The process was designed to ensure adequate representation of vulnerable social groups such as Scheduled Tribes and Scheduled Castes. For instance, there were efforts to select Mitanins from Particularly Vulnerable Tribal Groups (PVTG),[3] who would serve the areas where those people lived. This approach also limited the influence of local elites and dominant caste groups. As a result, the Mitanins who were selected could represent the people of their community. Selection was approved by local *panchayats*. This involvement of members of the local community from the outset was important in garnering the support and interest of people living in the villages.

Training was an important element of the Mitanin program from the beginning, and adopted a rights-based approach, highlighting the importance of addressing the social determinants of health (Nandi and Schneider 2014). Training is implemented through a cadre of around 4,000 Mitanin trainers—former Mitanins who have been promoted, and who receive training from SHRC in order to supervise Mitanins. Each supervisor/trainer oversees the work of 20–30 Mitanins (20–30 habitations or a population of 5,000–10,000, which forms a cluster). In addition to the trainings, meetings at habitation level and cluster level, known as *para-baithaks* and *sankul-baithaks* respectively, led by the Mitanin trainers, become an oversight and supervision platform for the Mitanins' work. These women were trained and supported to work as healthcare providers in their community, and were encouraged to take up multiple issues directly or indirectly related to health and well-being. The Mitanins' work came to be underpinned by a common mission—to secure the socioeconomic rights of their community.

Mitanins at a training session in Raipur.

Credit: Rupesh Yadav

At the inception of the Mitanin program, Mitanins were considered as volunteers—honorary, unpaid community-based mobilizers and health educators—and not government employees. Because they were not paid, the government had limited authority over them. Furthermore, they were and still are supervised by facilitators (Mitanin trainers) who are also not government employees, but part of the facilitation structure led by SHRC. These facilitators are paid by the state government, but they report to SHRC. However, in 2005, with the introduction of the National Rural Health Mission (a state intervention to improve health care in rural areas), Mitanins started getting paid by the government for their work through task-based incentives. Yet this did not negatively influence their autonomy as they were still not government employees and remain described as 'honorary' volunteers. However, since 2005, Mitanins have remained hugely underpaid and overworked (Som 2016).

The positive impacts of the Mitanin program on people's health status and health service delivery are well documented (Garg, Dewangan, et al. 2022; Nambiar, Sheikh, and Verma 2012; Tata Institute of Social Sciences and Department of Health and Family Welfare Chhattisgarh 2015). The rural infant mortality rate (IMR) of Chhattisgarh fell from 88 per 1,000 live births in 2001 to 61 per 1,000 live births in 2004—a decline of 27 percent within the program's first three years (Garg 2022), which equates to 17,000 newborn lives saved every year. Mitanins helped pregnant women attend antenatal check-ups, such that the number of women receiving four or more such check-ups in Chhattisgarh jumped from 19.4 percent in 1998 to 54.2 percent in 2005. This is particularly remarkable because Mitanins managed to do all of this and more in a state with weak public health infrastructure, a paucity of health workers, difficult terrain, and low education and income levels among the general population (Garg 2022).

As well as improving their population's health status, and health service delivery, literature shows that the Mitanins of Chhattisgarh have had a distinct impact because of their extensive engagement with issues beyond health rights. Independent researchers and program implementers have discussed how the program builds in learning as a key enabler for sustained, strategic action on public accountability that is focused on (but not limited to) health rights (Garg and Pande 2018). A qualitative study shows that Mitanins carry out work on the social determinants of health, as discussed earlier (Nandi and Schneider 2014). Another study showed that Mitanins belonging to Scheduled Tribes have helped to advance tribal communities' 'right to forest' in the northern district of Koriya. The Mitanins of different blocks[4] of Koriya, Sarguja, and Kawardha districts took collective action to resist state-orchestrated attempts at deforestation for commercial purposes, which would have been harmful for the tribal people whose livelihoods depend on the forests and the environment (Nandi and Garg 2017). However, due to limited evidence on the Mitanins' work on forest rights, we assume that the actions have been sporadic.

Our study adds to the literature on the Mitanins' work on the social determinants of health.

3. Methods

Survey data and qualitative data were both collected between March and June 2022. The survey was conducted to assess the proportion of Mitanins that are engaged in multi-issue activism, and the proportion of Mitanins that were involved in the three different domains of activism. All of Chhattisgarh's 146 rural administrative divisions (blocks) were included in the survey. Each block has around 400–500 Mitanins; four were selected from each block through systematic random sampling. The survey had a response rate of 95.5 percent. A sample size of 558 Mitanins was achieved.

The survey tool was divided into three domains (food security and nutrition; health care; and gender-based violence). Mitanins were asked to identify problems in their community related to these three domains, and to report any actions they had taken in the past three years to address those problems. These actions either involved providing people with information about their rights and entitlements, or negotiating with local officials; confrontation; and writing formal complaints to higher authorities. These latter actions, which went beyond providing information about rights and entitlements, were referred to in the survey as 'rights-based actions'. Of the Mitanins who reported having taken such actions, the most recent episode was documented.

We conducted 25 focus group discussions and 14 individual interviews to understand whether collective identity plays a role in driving the Mitanins' multi-issue activism. These discussions and interviews were conducted in six districts of the state. Districts in both plain and hilly areas of Chhattisgarh (with large populations of indigenous communities) were chosen. Mitanins were asked about how they perceived their role, how they thought the community and the government perceived their role, what were the enablers and barriers to their activism, and what motivated them to engage in activism. These surveys, interviews, and FGDs were conducted by program implementers in rural Chhattisgarh.

For the individual interviews, we reached out to Mitanins with the help of their supervisors. Some of the Mitanins who took part had been involved in 'remarkable work' (based on their supervisors' experience) on one or more of the three issues, while others were selected at random. In addition to the questions already mentioned, Mitanins were asked about their personal journey and experiences. These interviews were conducted in Hindi mixed with Chhattisgarhi, and were transcribed, and translated into English. The interviews were coded and the research team carried out thematic analysis.

Mitanins often write songs and slogans about their experiences and activism, which they perform during public rallies and public hearings, and at Mitanin meetings and trainings. As part of the research, they were asked to submit any songs they had written. We received 30 songs written in Chhattisgarhi, Halbi, and Sadri. Of those 30, we selected 10 that focused on rights-based work for content analysis. The textual content of the songs, received in written format, was analyzed with the support of native speakers from the program's implementation team. We used the songs and slogans as a tool to understand the relationship between collective identity and collective action. However, the relationship between caste identity and collective identity, and issues relating to labor rights, were beyond the scope of this paper.

4. Findings

4.1 Mitanin engagement in multi-issue activism

In this section, we first report the findings of our survey to estimate the proportion of Mitanins engaged in multi-issue activism. In our sample of 558 Mitanins working in rural areas, 42.5 percent belonged to Other Backward Classes, 36.2 percent to Scheduled Tribes, 17.2 percent to Scheduled Castes, and 4 percent to other castes. This caste profile was representative of the caste distribution of Mitanins and the general population of the state (Registrar General of India 2011b and c; Tata Institute of Social Sciences and Department of Health and Family Welfare Chhattisgarh 2015).

In the survey sample of Mitanins, 63.6 percent had attended high school, 18.3 percent had attended secondary school but not high school, 2.9 percent had attended primary school but not secondary school or high school, 7.3 percent were literate but had not attended school, and 7.9 percent could not read or write.

The survey asked Mitanins about their activities. As noted earlier, any actions that went beyond providing information were referred to in the survey as 'rights-based actions'. These appeared to take diverse forms. Mitanins reported having intervened in situations where community members were denied their health rights at a health center, or a public hospital, either by not receiving treatment, or being mistreated by health workers. The survey showed that Mitanins confronted sales staff in ration/grain shops, or wrote formal complaints when people were denied their food-related entitlements by being overcharged or given adulterated grains. Some reported having supported survivors of gender-based violence to take legal action and accompanied them through procedural technicalities. They raised issues affecting their communities during annual *jan sammelans* (dialogue forums) where officials with decision-making power were present, and engaged with local representative institutions such as *panchayats*.

However, Mitanins also clearly play an important role in providing information to community members, including information about their rights and entitlements under government programs or policies, which is often not accessible to common people in India. For the purposes of the survey, we defined activity such as providing information on rights and entitlements as 'any action'. On health care and food security, this meant providing information to people about their entitlements; on gender-based violence, it included supporting survivors and counselling perpetrators.

A key finding of our survey was that in the preceding three years, 84 percent of Mitanins had participated in rights-based action in at least one of the three domains. In the previous year, most actions involved food security and nutrition (42 percent of Mitanins), health care (34 percent), and gender-based violence (11 percent). These proportions are higher when 'any action' is included: Mitanins took action on food security (54 percent), health care (51 percent), and gender-based violence (29 percent) (see Table 1).

Table 1. Mitanins Engaging in 'Any Action' and 'Rights-Based Action' (n=558)

Domains of action	Last three years		Previous year	
	Any action	Rights-based action	Any action	Rights-based action
Food security and nutrition	83%	68%	54%	42%
Health care	80%	56%	51%	34%
Gender-based violence	48%	21%	29%	11%
Action on at least 1 of the 3 domains	**96%**	**84%**	**72%**	**56%**

4.2 Defining the Mitanins' collective identity

We propose a composite definition of the collective identity of Mitanins based on the words that several of them used during interviews and discussions:

> A sense of solidarity that all Mitanins share with the community they serve, and belong to, and a feeling of sisterhood with other women and each other. It is the shared experience of being a group of empowered women with a common mission who must use their knowledge and compassion to support the people they serve, especially the marginalized, in every aspect of their life. The value system underpinning their mission dictates that people should not be denied their rights, and marginalized people should not be treated unfairly by the state.

Our qualitative data showed that the Mitanins' collective identity is layered. They are more than just frontline health workers in a government-run program; they are also problem-solvers (addressing the problems facing people in their community, and showing solidarity with the most marginalized sections of society), and activists (struggling for the rights of the people they serve). One Mitanin who has been associated with the program for 19 years summed this up:

> *Mere hisab se to Mitanin logon ko swasthya seva toh deti hi hain, logo ko unke aadhikar bhi dilwati hai, chahe wo swasthya suvidha se juda ho ya ration se juda ho. Hum sab se yahi koshish karte rehte hain ki logo ko sarakri suvidhayon ka labh mile, khas kar ke jo kamzor, garib varg hain unhe yeh suvidhayein milna chahiye.* (Mitanin workers not only provide health services to the people, but help them to exercise their rights, no matter if it is related to health care or getting food in a ration shop. We all try to make sure that people get the services provided by the government, especially the weakest and poorest. They should not be deprived of these services.)

Mitanins discussed that they share a strong bond with their fellow Mitanins, which is linked to their common mission to serve the people, especially other women in the community. In the following subsections, we describe the multiple layers of the Mitanins' collective identity.

4.2.1 Solidarity with the community

Mitanins saw themselves as women who feel solidarity with the people they serve. They care about the well-being of the people in their community, and are committed to taking up issues that affect them. Our qualitative findings show that Mitanins do a lot of unpaid work in their activist capacity, which has not been prescribed by the government. Mitanins report that they gain immense satisfaction and joy from being able to help people, especially the poorest people in their community, in addition to being a service provider.

Mitanins shared that they enjoy working for their community the most, as opposed to doing some relatively "futile" tasks for the government like "unnecessary" data collection. They said that their activist work was more "meaningful" to them. They draw this meaning from the concept of solidarity. During focus group discussions, Mitanins shared their strong belief that people must be able to access social security, livelihood entitlements, and free health care in public hospitals. They spoke earnestly about the rights of marginalized people, including elderly people and people with disabilities. Mitanins unanimously believe that people must claim their rights, and that this pursuit of solidarity—by means of helping people, solving their problems, and claiming their rights—is what defines them.

"Mitanins unanimously believe that people must claim their rights, and that this pursuit of solidarity—by means of helping people, solving their problems, and claiming their rights—is what defines them"

Box 1. Confronting Health Officials and Demanding Healthcare Services

"There was an increase in diarrhea cases in the village and we were not able to control it at our level. We [a Mitanin, and her supervisor] requested the Block Medical Officer[5] to visit the village and set up a camp [for treating people].

But the village is surrounded by big canals, and there was a lot of water flowing. They didn't want to come here.

A young child was ill due to diarrhea. When I called the nurse, she just told me to give oral rehydration salts, which I was already giving, but his situation was not improving. Similarly, an old man was sick too, and was very weak. Many other people fell sick in the coming days, and the situation got worse.

The Block Medical Officer came as far as the edge of the village and we all met him. He said we have limited resources at the block level. But I argued with him, and said that people here deserve treatment, and we are carrying them to the hospital with such difficulty. There are small children, and old people who are sick. I told him, 'if anything happens to the remaining people who are sick, it will be your fault, because you are not ready to set up a camp'.

He then set up a camp, and people were treated."

Source: Notes from an in-depth interview with a Mitanin associated with the program for 16 years (May 24, 2022).

A Mitanin accompanies a disabled woman to the local hospital.

Credit: Rupesh Yadav

The sentiment of solidarity is also evident from the songs that have been written by Mitanins on the right to health. These songs narrate the challenges that people in their community face in a hospital setting (misbehavior, delayed treatment, or the denial of care) or at a ration shop (denial of food entitlements, overcharging). In a song about health (Song 1), the Mitanin conveys the emotions of witnessing people's suffering and the everyday struggles to get dignified health care. The songs show that Mitanins feel people's suffering deeply, and share a sense of solidarity with them. Health-related slogans that Mitanins have written also emphasize the right to free health care—reflected in the use of the word *firi*, a colloquial term for 'free'. The song emphasizes the idea that poor and working-class people have the right to free health care in government hospitals; and Mitanins motivate everyone in their communities to exercise this right. They also assert people's right to dignity and respect in healthcare settings and when interacting with health workers.

Song 1. Right to Free Treatment

अवाज उठायेंगे तो अधिकार पायेंगे,	*If we raise our voices, only then we will get our right*
पर्ची कटाने के लिये गरीब लोग लाइन लगाते हैं,	*Poor people stand in long queues in the hospital,*
बड़े लोग लाईन नहीं लगाते हैं, सीधे पर्ची कटाते हैं,	*Rich people do not have to stand in queues…*
शासन द्वारा फ्री ईलाज मिलता है, और मिलना भी चाहिए!	*Government provides free treatment, as it should!*

Another song (Song 2) talks about the everyday challenges facing people when they go to a ration shop: delays in getting food, adulteration of grain, or denial of entitlements by the salesperson. The Mitanin wrote this song on behalf of the community she serves. Through this song she asserts that the community has the right to food-related entitlements, and that they should not be denied that right. She expresses that the community must take a stand against unfair practices, and denial of food-related entitlements.

Song 2. Right to Food and Respect

35 किलो चावल बर दू दिन ले मोला घुमाथे गा,	*The shopkeeper keeps me waiting for 2 days for 35 kilograms of rice*
चावल म अब्बड़ गोटी रइथे,	*Rice is mixed with stones: I have to clean it slowly to be able to eat it.*
ओला बिन–बिन मैं ह खाथव गा...	
मैं हा जाथव...	*I go to the ration shop…*
तोर नाम म गैस हाबय कइके माटी तेल बर मोला सुनाथे गा	*"Why do you need kerosene oil when you have liquid petroleum gas in your name?" the ration salesperson asks me.*
मैं हा जाथव...	
चावल भर में पेट नई भरय के सबो समान ह मिलतिस गा	*I should get enough for us to feed ourselves,*
ये हे मोर अधिकार दीदी	*it is my right to get everything the government is meant to provide.*
बाकी समान भी मिलतिस गा...	
मैं हा जाथव...	

4.2.2 Leaders who empower the community

Mitanins believe that people view them as community leaders—women who solve people's problems because they are equipped with knowledge and information about entitlements and rights that is otherwise difficult to access. Of 14 Mitanins who were interviewed, nine said that they felt the community saw them as a person who wields knowledge and power, in a way that she uses for the benefit of the community. During an interview, one Mitanin said:

> *Koi bhi pareshani aati hai toh log humare paas aate hai, humse umeed karte hain ki hum unki pareshani hal karein, aur aise muddon ko uthaye jis sabko pareshani ho rahi hain*. (When people face any problem, they come to us. They expect that we can solve their problem, and can raise issues that everyone faces problems with.)

Mitanins work closely with government actors, and have managed to build working relationships with them. This gives them certain leverage relative to the government system, which contributes to community perceptions of Mitanins as leaders. One Mitanin described this:

> *Hum jab logo ke sath hote hain, chahe aspatal mein ya ration dukan mein, waha nurse, doctor aur ration dukaan chalak, mai logo ki pareshaniyon ko un tak le ke jati hu. Unhe lagta hai Mitanin ko niyam pata hai, uske ke pas sarkari aadesh bhi hote hain, iss liye wo meri sunte hain. Wo bolte bhi hain, "Bhaiya, Mitanin sab janthe"*. (When we are with people at the hospital or at the ration shop, we try to take their issues to the nurses, doctors, or staff there. They listen to me seriously because they know Mitanins know the rules, and have access to information on the latest government orders. They say "Mitanins knows everything!".)

Mitanins also felt that they are seen as approachable leaders, unlike other local leaders such as the *sarpanch* (the elected head of the village *panchayat*).

The Mitanins' collective identity is strengthened through the support they derive from their supervisors, training sessions, formal meetings, committees, and the forums for collective learning, which are part of the design of the program (Champa 2017). For example, annual training sessions conducted by SHRC usually take place in government buildings across the state, when between 300 and 400 Mitanins meet at district level and stay together for more than a week, creating an atmosphere of solidarity and allowing for sharing of collective struggles, in addition to technical learning. Each annual training event includes at least one session on rights-based work, giving Mitanins information about government programs and schemes, and the confidence to intervene and assert people's rights on issues of concern (Nambiar and Sheikh 2016).

Mitanins also mentioned the role of formal meetings like *para-baithaks* and *sankul-baithaks* (habitation- and cluster-level meetings), and the information about health entitlements that is shared during those meetings, as something that empowers them to continue advocating for people's right to health. Similarly, formal dialogue forums like *jan sammelans* (public hearings) allow Mitanins to meet with people's elected representatives and share their concerns face-to-face. Another important institutional platform is the Village Health, Sanitation and Nutrition Committees (VHSNCs) that were introduced by the government in 2005. Mitanins are the member secretaries of these committees along with other community members and elected representatives (*panchayat*). Mitanins convene the meetings and utilize this platform to raise issues in the presence of *panchayat* members and community members.

Mitanins raise community rights issues at a *jan sammelan* (public hearing) in Raipur.

Credit: Rupesh Yadav

All of the Mitanins we interviewed said that people usually come to them first if they are denied their right to health care or food, and even sometimes when they have experienced gender-based violence, because Mitanins are always open to helping other people. Therefore, being a Mitanin means being a problem-solver, who carries the multiple responsibilities of the community, and who is easily accessible to everyone in the community.

"Being a Mitanin means being a problem-solver, who carries the multiple responsibilities of the community, and who is easily accessible to everyone in the community"

During an interview, one Mitanin shared that community members and rations shop salespeople in her village see Mitanins as women who work on several issues. She said that government health workers such as nurses and doctors see Mitanins as people who advocate for people's rights even though they work for the government. During a focus group discussion, some Mitanins shared that people do not link them to one particular activity: "*Hum sirf swasthya ka kam nahi karte, koi ek kaam nahi karte*" ("our work is not limited to health or any one kind of work") and "*Hamaari pehchaan kisi ek kaam se nahi judi hai*" ("our identity is not tied up with one task").

Mitanins see themselves as leaders, as women who have taken up responsibility for the good of their community. As one Mitanin said during an interview, "*Hum logon ke sukh dukh ki sathi*" ("we are the people's friends in good times and in bad times"). She valued the fact that she is viewed within her community as someone who is dependable, like a *didi* (elder sister). Mitanins deeply identify with the idea of being a female friend to all the women of the community.

4.2.3 Sisterhood

The Mitanins' collective identity is also linked to the fact that they are all women, as are the majority (90 percent) of trainers. The Mitanin program is also run and coordinated largely by women. Mitanins have been able to forge solidarity with each other, their female supervisory cadre, and other women in their communities. One Mitanin described this as empowering, saying "We have our own identity now. Earlier I was known by my husband's name. That is not the case anymore."

Sisterhood and the solidarity associated with it are also conveyed through some of the songs written or sung by Mitanins. During a focus group discussion, a 38-year-old Mitanin from a hilly district said: "Other women like our work because we are playing a role beyond the confines of our homes, we attend meetings, learn important information, and share it with others [talking about government schemes]."

This shows the overlap and interaction between the social identity of being a woman, and the collective identity of being a Mitanin (Snow and Corrigall-Brown 2015). During a focus group discussion, Mitanins shared how they take pride in having a voice in otherwise male-dominated spaces, including *panchayat* meetings. They are setting an example for other frontline workers and for women from marginalized communities by entering spaces where men and dominant caste groups are 'gatekeepers'. One Mitanin, speaking about their presence in meetings of the *gram panchayat* and Village Health, Sanitation and Nutrition Committee, said: "*Pehele mahilayon ke mudde nahi sunbe karis, par hamar man ke pareshani bhi sunbe lagthes*". ("Earlier they wouldn't listen to matters pertaining to women. Now they have to listen.")

There are songs written by Mitanins that talk about the perils of living in a patriarchal society (see, for example, Song 3). Mitanins motivate other women to liberate themselves from the shackles of patriarchy, and the caste system. These songs are about women's rights, and the social ills related to gender discrimination. Song 3 is about being inferior to no one—therefore challenging the fundamental idea of caste-based hierarchy. It also mentions the atrocities that have been perpetuated on women, specifically on women from marginalized castes by both men and women of dominant caste groups. In some songs, Mitanins exclusively call for women referred to as "mothers" and "sisters" (*maiya, bhahin*) to take action for their rights, and for their future.

However, the notion of sisterhood between Mitanins is not free of prejudice and discrimination. Caste is an omnipresent reality in India, specifically in rural India. In a few interviews, Mitanins belonging to Scheduled Castes shared experiences of discrimination by dominant caste Mitanins (including Brahmins, Kshtariyas, and Vaishyas). This clearly highlights some unequal power dynamics among Mitanins, despite their being 'united' in their identity as community health workers. Therefore, we argue that the Mitanins' 'social identity' (both on an individual and group level) cannot be ignored while talking about 'collective identity' (Bros 2010). Caste differences could lead to conflict among Mitanins and adversely affect their notion of collective identity. But how do Mitanins face these conflicts and continue to work with a common sense of mission? Pizzorno (1978) suggests that in an internal conflict situation, people continue to maintain a bond with others not because they share the same interests, but because they need this bond in order to make sense of what they are doing. Our qualitative exploration shows that although Mitanins are not spared from caste-based discrimination by fellow Mitanins, these divisions are not strong enough to create a rift between them. Based on our implementation experience with the program, we argue that an adequate representation of Mitanins from marginalized caste groups (proportional to their population in the state) has allowed Mitanins to pursue their activist work despite these divisions.

Song 3. **I am Today's Woman, I am Inferior to No One**

मैं आज की युग की नारी हूँ...	*I am today's woman,*
न अबला ना बेचारी हूँ, मैं आज की युग की नारी हूँ,	*I am not a damsel in distress, I am today's woman*
कम करके मुझको मत आंको, मैं सारे जग पर भारी हूँ,	*I am inferior to no one, I hold power over the world*
ना अबला ना बेचारी हूं, मैं आज की युग की नारी हूँ...	*I am not a damsel in distress, I am today's woman*
सदियों से भी औरों के लिए सदियों से अत्याचार सहे,	*We have endured atrocities since centuries,*
हर बात की सीमा होती है, ऐसे घुट–घुट कर कौन रहे,	*there is a limit to everything, shackles will not bind us.*
नहीं डरती हूँ मैं दुनिया से अपनो से सदा हारी हूँ...	*I am not afraid of the world, but I have always lost to my own people.*

4.3 What factors have shaped the Mitanins' collective identity?

4.3.1 The program's movement-building approach

The approach adopted by the Mitanin program can be seen as movement-building, as it enabled Mitanins to nurture their activist tendencies. This is in line with Wilkinson's understanding of a social movement as "a deliberate collective endeavor to promote change, which must involve some degree of organization. The raison d'etre of its organization is founded upon conscious volition, normative commitment to the movement's beliefs, and active participation" (Wilkinson 1971, 29).

Two aspects of the movement-building approach (discussed in section 2.2) were critical to building the Mitanins' collective identity: the selection process, which encouraged community participation and ownership; and the focus during training on a rights-based approach (rather than a bio-medical approach) to health and its wider determinants. From the beginning of the program, women who cared about the well-being of the community, showed interest in working for people's welfare, and displayed leadership skills were the ones who volunteered to work for the people, as community health workers.

Over time, this approach meant that Mitanins were able to gain the trust and respect of the community. Our findings illustrate how Mitanins have been able to translate this into action, by organizing their community to take a collective stand when they are denied their rights, sometimes even bringing them into confrontation with village elites.

In one of the interviews, a Mitanin who had been involved with the program since the beginning shared an anecdote to highlight the extent of support they receive from people in their community, and how they are perceived as community leaders.

> We [the community] were entitled to get extra rice during the pandemic as per the government orders but we were not given the extra rice by the salesperson of the ration shop. I wrote an application and they [the community members] all supported us [Mitanins]. The *sarpanch* [head of the village], who was earlier unwilling to act, ordered the salesperson to provide everyone with extra rice.

4.3.2 The Mitanins' autonomy

In line with some other community health worker movements (initiated by civil society) in other states of India, at the inception of the program, Mitanins were not paid for their work (Som 2016). Although feminist scholars argue that this was a form of unpaid labor extracted from women (Som 2016), it did mean that most women who came forward to take part in the program had an inclination towards social work and activism. An ethnographic study showed that being a part of the Mitanin program had "awakened" their feelings compared to any other previous jobs they had (Champa 2017). In 2020, they were paid 60 percent less than the legal minimum wage for the type of work they do (Garg, Dewangan, et al. 2022).

We found that Mitanins see themselves as volunteers as they work on a task basis, even though they get paid a nominal amount for the work they do. They shared that they have been able to exercise a certain degree of autonomy compared with other 'formal' health workers who receive a higher, fixed salary and other employment benefits. As one Mitanin said: "*Hum Mitanin log swayamsevi hain*" ("We Mitanins, we are volunteers"). Another said: "We can decide when and how we want to work, and we are not told how to do things on the ground." Mitanins explained that they can exercise their agency when it comes to health-related work. Also, their work on food, and gender-based violence, does not require any reporting, which allows more freedom and flexibility to address these problems as each Mitanin deems appropriate. They believe that they are available for the community 24/7, because they are not bound by fixed hours of work. They describe themselves as linked to government but not government employees.

However, the voluntary nature of their work makes their working conditions highly precarious. Many pointed out that they experience pressure from local government employees and elected representatives (such as the *sarpanch*) to undertake certain tasks that seem futile and which they do not particularly enjoy doing. According to Mitanins, these tasks usually involve some form of data collection, and rarely any work that 'directly' benefits the people of their community. Similarly, Mitanins reported that they sometimes face repercussions for their actions, as these are often at odds with the interests of local elites (such as the salesperson of the ration shop) and government health workers (nurses or doctors, for example). Mitanins did, however, explain that they have developed tactics (such as taking support from the community members and their supervisors) to handle such occurrences, both at an individual and collective level.

4.4 Collective action and its relationship with collective identity

Songs, slogans, and similar rituals have been utilized by social movements to define and nurture collective identities. The spaces in which these songs are sung and slogans are raised are filled with emotions, and they play an important role in the development of collective identity (Danaher 2010). The content of these songs and slogans touches on the social and political identities of those involved, to convey a sense of shared community (Smith 2018). Mitanins write songs about their activist experiences, to raise awareness, and to mobilize people in their own community and other Mitanins (see page 16 and also sections 4.2.1 and 4.2.3 for examples). Content analysis of these songs and slogans helped us to understand the relationship between the Mitanins' collective identity and collective action.

A recurring theme across the three rights-based domains was the use of words like *haq, aadhikar* (rights) in Hindi, Chhattisgarhi, and Sadari[6] songs. Songs about health rights use *haq/aadhikar* in relation to free health care in government hospitals; songs on food security use these words in relation to fair pricing and quality; and songs on gender-based violence use these words in relation to the rights of women and girls. The songs convey a sense of solidarity and evoke feelings of togetherness in the struggle to seek the right to health care, food security, or freedom from gender-based violence. As such, they can be seen as "songs of resistance" (Carruyo 2005), which create a sense of community and collective opposition to perceived injustice, drawing on local lived experience in local dialects.

Mitanins use song to convey their lived experiences of the challenges of activist work, mobilizing action against unfair practices. The songs on gender-based violence make a strong social and political commentary that is itself a form of resistance. The healthcare rights and food security songs focus on mobilization for action. Sociologists have argued that resistance requires friendships and connections, possibilities of empowerment, as well as a sense of community through which people care more and think more about what they can do together to feel better or simply to survive (Courpasson and Vallas 2016). The Mitanins' songs embody solidarity and resistance. The songs show that Mitanins are not only concerned about their community, but also that they see it as their duty to engage in matters that may not be directly related to health, even though they are not paid for work beyond their remit. These songs, evoking solidarity, elucidate that the Mitanins' collective identity comes primarily from the work they do and from a sense of sisterhood. The Mitanins' links with government, coupled with their solidarity with their community, gives them social recognition and credibility, yet their sense of duty to prioritize community rights and needs imparts a sense of fulfillment, increases their morale, and contributes to sustaining their motivation.

Mitanins going to a health center in Surguja.

Credit: Rupesh Yadav

Song 4. Claiming Rights

भईया रे सबे चला जाब आपन हक मांगेक ले...	*O brother, let us all go to claim our right*
बहिन रे सबे चला जाब आपन हक लेवेक ले...	*O sister, let us all go to claim our right*
मनरेगा काम में सप्ताह पैसा नहीं मिलेला...	*In the job guarantee scheme,[7] we did not get paid on time*
मईया रे सबे चला मांगेक ले...	*O brother, let us all go to claim our right*
बहिन रे सबे चला...	*O sister, let us all go to claim our right.*

Over the past 21 years, the Mitanins' activism in the various domains they engage with has gradually evolved. They have been working extensively on food security, given that the mandate of entitlements under the PDS remains clear. Activism related to the PDS often involves challenging local elites (usually the ration shop salesperson or the *sarpanch* at times) to secure people's rights. Mitanins also raise issues related to the PDS in Village Health, Sanitation and Nutrition Committee meetings, such as denial of entitlements, poor quality of grains, and unfair pricing. Often, Mitanins work with other Mitanins and their supervisors who offer support to bring up contentious issues in front of local elites, the *panchayat*. This has been possible because of a sense of trust and sisterhood among Mitanins. They also receive support from community members (villagers), particularly on matters of food security. During one of our interviews, a Mitanin said that community members feel that Mitanins go above and beyond what is required of their role (health work) to address issues of food security, and so the community gives unanimous support to Mitanins:

> *Maine pichle hafte ek buzurg ko ration dilwane me madad ki tab wah mujhse yeh keh rahe the ki tum log sab ke liye daudte ho, chahe pareshani kuch bhi ho. Logon iss baat ko hamesha bolte hain.* (Last week I helped an elderly person to get his ration, so he said to me that Mitanins like you always take effort to solve people's problems regardless of which problem it is. People always say this to us.)

Mitanins at a Village Health, Sanitation and Nutrition Committee meeting in Gariyaband.

Credit: Rupesh Yadav

In another focus group discussion, Mitanins shared that the community supports them whenever they challenge any malpractice by the sales staff of grain shops. According to Mitanins, the community gives that support for more than one reason: "People are aware that we don't get paid for the work we do on food security."

Mitanins have been able to evolve various individual and group-level tactics to ensure public accountability with respect to the food security schemes. For example, they monitor the pricing, timeliness and quality of food grains provided through ration shops. They are also usually up to date with any changes in relation to entitlements to food. They wield the power of information and the support of their community on these issues.

However, Mitanins have not been able to have a similar impact on issues of gender-based violence. In a study on accountability work done by Mitanins, Champa (2017) found that efforts on collective action were sometimes stalled due to differing attitudes among villagers towards the issues being tackled. Mitanins find it challenging to address gender-based violence due to the stigma surrounding the issue, and hence the lack of community support on this issue. During interviews, Mitanins reported that they do get involved with cases of gender-based violence each month and attempt to address the issue by taking it up with the local police, and at government-run Sakhi centers (which provide support and redressal for female survivors of abuse). However, the complex nature of the problem from a societal and legal standpoint, and weak community support on the issue, makes it difficult for Mitanins to "address" the problem even when they intervene frequently.

It must also be noted that action by Mitanins on community forest rights is sporadic given the high risks involved; these actions have led to legal action in some cases. Mitanins have been able to take some risks on issues of food security, which often involve dealing with local elites; but there is a limit on the extent to which they are able to undertake actions that involve much higher levels of risk.

5. Conclusion

This Working Paper has analyzed the patterns of autonomous collective action through discussion, interviews, and the rights-based songs and slogans written by Mitanins. We argue that the Mitanins' collective identity is central to the multi-issue activism they undertake to defend the social and economic rights of the people in their community. We found that this collective identity emerged as a result of the program's movement-building approach and the autonomy it gave to Mitanins on the ground. The program has enabled Mitanins to engage in multi-issue activism despite being state-funded actors. As a hybrid agency, SHRC has supported and fostered the original vision of Mitanins as activists and community leaders, and has carefully nurtured the Mitanins' ability to engage in and sustain multi-issue activism.

We found that the Mitanins' collective identity is layered, and shaped by their own sense of duty and service to their communities. Our findings also show that the Mitanins' activism is driven by their idea of collective identity. Mitanins view themselves not merely as frontline government health workers but as a group of women leaders who care deeply about the rights of the people in their communities. Mitanins find their activist work meaningful, explaining that it gives them a sense of purpose. They draw this meaning from the concept of solidarity, which they share with the community that they serve and to which they belong. They are enthusiastic problem-solvers and activists who are working, collectively and individually, to defend people's rights to health, food security, and freedom from gender-based violence, as well as other rights that people may be denied. Mitanins strongly believe that people should have access to social security, livelihood entitlements, and free health care in public hospitals, and this belief gives them a shared mission, a common cause to work on. Their shared experiences of serving their communities has, over time, strengthened the bond among Mitanins, and they believe that their communities view them as community leaders. This notion of collective identity is also linked to their identity as women, who stand by each other and by other women in their community.

Mitanins are state-funded actors (community health workers), but their activism beyond healthcare delivery is enabled by movement sensibilities that focus on social mobilization and rights activism on behalf of their communities.

The Mitanins' evolving collective identity shows that when community-based workers (health workers in this case) are viewed as more than link workers, and supported to combine their work with rights-based advocacy, they can defend community rights, and even become community leaders.

Notes

1 This exercise was part of the Accountability Research Center's (ARC) work on health rights and accountability, focusing on learning from and with the people that ARC calls "frontline health rights defenders", in Colombia, Guatemala, Philippines and India. ARC provided technical and analytical support to the State Health Resource Centre of Chhattisgarh to document and disseminate the experiences of Mitanin community health workers on accountability action, in order to inform global agendas on community health workers, public accountability, and health rights advocacy.

2 *Panchayats* are statutory elected village councils, and form the lowest level of local rural government. In Chhattisgarh, a *panchayat* has an average population of around 2,000 across a few villages.

3 Particularly Vulnerable Tribal Groups (PVTG) are a sub-classification of Scheduled Tribes.

4 A block is a rural administrative unit in India. In central India, it usually has a population of between 50,000 and 200,000 spread across 100 to 200 villages.

5 A Block Medical Officer is the head of medical services at the block administrative level.

6 A dialect spoken in north-eastern district of Jashpur in Chhattisgarh.

7 Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) is a livelihood security scheme for rural households. It provides year-round employment with a minimum guarantee of 100 days of wage employment each year to every household volunteer to do unskilled manual work.

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