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Learning to Sustain Change: Mitanin Community Health Workers Promote Public Accountability in India

Samir Garg
Suchi Pande



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About the Authors



 **Samir Garg** is a practitioner involved in the implementation of the Mitandin program. He has worked for 22 years on the public governance of health and food security in India, including as an Adviser to Supreme Court Commissioners on the Right to Food. He is currently working with State Health Resource Centre and pursuing his PhD in Health Systems Management at Tata Institute of Social Sciences, Mumbai. His areas of interest are community participation and management of health and other public systems.

 **Suchi Pande** is a scholar in residence at the Accountability Research Center, School of International Service, American University. She is associated with India's National Campaign for People's Right to Information, and the Rajasthan-based Right to Information and Work campaigns. Suchi's research focuses on social movements, state-society relations, public accountability, and social justice campaigns.

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Summary

Learning to Sustain Change: Mitanin Community Health Workers Promote Public Accountability in India

Can community health workers (CHWs) act as agents of change in enhancing the public accountability of government, despite being state-funded actors themselves?

CHW programs worldwide face challenges in achieving public accountability. They face a tension between upward accountability (to higher officials within the health system) and public accountability (to the people who access and use public health services), especially with respect to their potential to play a role as agents of public accountability (Schaaf et al. 2018).

This *Accountability Note* illustrates how the CHW program of the Chhattisgarh state government in central India—known as Mitanin—has, over time, developed a learning strategy that permits CHWs (Mitanins) to enable sustained action on public accountability, whilst simultaneously providing health services and education, and linking communities with government healthcare services.

The main proposition of this note is that this evolving learning strategy enabled state and civil society actors to design institutions and processes appropriate for accountability. Our focus is on understanding how learning has lent the program the ability to evolve ways for continuously managing the essential tensions inherent in its design, and how this has been key to developing sustainable accountability strategies.

We discuss examples of how the Mitanins' evolving learning strategy has contributed to their efforts to ensure public accountability of the health system to people who use public health services. These examples are grouped under five propositions about the roles CHWs can play in sustainable public accountability:

1. Community health workers can simultaneously act as service providers and agents of public accountability.
2. Community health workers can set agendas for advocacy on issues of accountability by building virtuous cycles of action and learning.
3. Community health workers can build countervailing power at multiple levels.
4. Community health workers can demand both rights for communities, and better working conditions for themselves.
5. 'Action-strategists' can create an appropriate state-civil society organization to facilitate community health workers' action.

This note offers insights from the Mitanin experience on these five ways that CHWs can build and sustain accountability, and illustrates how the program has taken a movement-building approach to public health, and thus avoided becoming a narrow technocratic intervention.

Map 1. India – States



Map 2. Map of the State of Chhattisgarh



I. Introduction



Mitanin is a government community health worker (CHW) program which has been in operation since 2002 in the central Indian state of Chhattisgarh, one of the poorest in the country, where 31 percent of the population belongs to indigenous tribes (Registrar General of India 2011). There are 70,000 women CHWs, called *Mitanins* (friends¹), who reach around 24 million people across 20,000 villages and 3,800 urban slums. They provide health, education, link communities with formal government healthcare services, and mobilize community action for health rights.

The program is implemented through a structure of around 4,000 supervisors-cum-trainers, former Mitanins who have been promoted. This structure is stewarded on behalf of the state government by the State Health Resource Centre (SHRC), a semi-autonomous institution created specifically for this role by state and civil society, and an example of what the literature refers to as a ‘boundary organization’ that straddles the state-society interface.² In this note, we use ‘support structure’ to refer to this multi-level network of supervisors-cum-trainers and the SHRC, which work at village, cluster, block, district, and state levels. This network plays a central role in selecting, training, and mentoring Mitanins, developing their multiple roles as service providers and community leaders, and providing leadership for them at various levels (see Champa (2017) and Nandi (2014) for detailed descriptions of this structure).

The Mitanin program has been described as a scaled-up government-run CHW program (Nambiar and Sheikh 2016). Researchers have also examined its achievements in improving health and health-service indicators (Misra 2011; Sundararaman 2007; Vir et al. 2014); its impacts on social determinants of health (Nandi et al. 2014); the role of its innovative facilitation structure in fostering collective action (Garg 2016; Garg 2017; Kalita et al. 2012; Nambiar and Sheikh 2016; Nandi and Schneider 2014); trust between Mitanins and communities for action on social accountability (Champa 2017); and the political commitment of the Chhattisgarh state

government toward the program (Kalita and Mondal 2012; Nambiar and Sheikh 2016).

However, Mitanin has more to offer in terms of insights for accountability and ways to sustain it. The program represents a case of building in learning as a key enabler for sustained, strategic action on public accountability of the health system to people who access and use public health services. The main proposition of this note is that an evolving learning strategy enabled state and civil society actors to design sustainable institutions and processes appropriate for accountability. Our focus is on documenting how learning has enabled the Mitanin program to evolve and advance multiple, sustainable accountability strategies while managing the essential tensions inherent in its design.

CHW programs worldwide face challenges in demanding public accountability,³ especially when they are state-funded, and must therefore be accountable upwards to senior officials in the health system, rather than downwards to people who use and access the services they provide (Schaaf et al. 2018). Despite being fully funded and owned by the state government, the Mitanin program has demonstrated large-scale public accountability action by CHWs, sustained over more than a decade. Many of the Mitanins’ actions can be viewed as what Fox (2015) describes as a “strategic approaches” to accountability. Not limited to information sharing or using monitoring tools like score-cards, Mitanins have instead combined a variety of iterative strategies to strengthen public accountability, mobilizing different categories of citizens to demand health care that is affordable, secure, and accessible to all. By taking a movement-building approach to public health, the program has avoided becoming a narrow technocratic intervention.

Several understudied and fundamentally important questions emerge from the Mitanin experience:

- How can a state-run program engage in large-scale public accountability efforts?

- What factors have enabled Mitanins to build and sustain their autonomy from the health system bureaucracy, as well as from the rural elite?
- How have Mitanins enacted a movement-building approach to public health service delivery?

This *Accountability Note* analyzes the Mitanin program from an implementer's perspective,⁴ focusing on the Mitanins' iterative, strategic actions to strengthen public accountability. It is deliberately structured to focus on the Mitanins' evolving learning strategy for public accountability.⁵ It combines participant observation by a member of the SHRC, data from SHRC public archives and official documents, and interviews with Mitanins, government officials, service-providers, politicians, and activists.



Mitanins protest forest felling and transportation of logs, May 2006.
Credit: © Sulakshana Nandi

II. Learning by Community Health Workers for Sustainable Public Accountability



In this section we discuss five ways in which the Mitanins' evolving learning strategy has contributed to their efforts to ensure public accountability of the health system to people who use public health services. These are grouped by five propositions about the roles CHWs can play in sustainable public accountability.

1. Community health workers can simultaneously act as service providers and agents of public accountability.
2. Community health workers can set agendas for advocacy on issues of accountability by building virtuous cycle of action and learning.
3. Community health workers can build countervailing power at multiple levels.
4. Community health workers can demand both rights for communities, and better working conditions for themselves.
5. 'Action-strategists' can create an appropriate state-civil society organization to facilitate community health workers' action.

1. Community health workers can simultaneously act as service providers and agents of public accountability

Accountability in government programs often tends to be mainly upward in orientation, with close bureaucratic control over the selection and performance of government employees. However, according to the program design at the beginning, Mitanins were considered as volunteers—honorary, unpaid community-based mobilisers and health educators—and not government employees. They were not paid, which meant that the department had little authority over them. Further, they were and still are supervised by facilitators who are also not government employees, but part of the facilitation structure led by SHRC; although facilitators are paid by the state government, they report to SHRC. This dual accountability structure for supervisors reduced potential government control from the start of the program, and ensured that upward accountability pressures on Mitanins were weak.



A Mitanin performing a malaria test in Bhatigarh village of Gariyaband district, 2018. Credit: © Satyaprakash Sahu.

The selection process for Mitanins also laid the foundations for building a movement rather than a technocratic intervention, by deliberately including the participation of community members. Selection was managed by non-government facilitators, recruited by SHRC from the communities where Mitanins work, and sharing similar socio-economic characteristics.⁶ The training of these facilitators and the partial embedding of selection in communities was intentionally designed to anticipate and push back against capture of the process by local elites. The process was also consciously structured to ensure adequate representation of vulnerable social groups like Scheduled Tribes and Scheduled Castes. As a result, the Mitanins selected were seen as community representatives, not just local extensions of the state government. This design, based on volunteers and an accompanying social mobilization campaign, was a strategy that members of SHRC adapted from the national adult literacy movement of the preceding decade.⁷



A Mitanin raising a question in Jan Samwad (Public Dialogue) forum organized in Manendragarh block of Koriya district, 2011. Credit: © Sulakshana Nandi

The Mitanin was envisioned by SHRC as a community leader, acting to address multi-sectoral needs— based on the understanding that health itself is linked to clean water, the environment, nutrition, gender, and people’s livelihoods and social support (SHRC 2003). Mitanins combined three roles—service provider, link with government healthcare services, and advocate demanding better health services. It is their role as advocates that is centrally important to their strategic action on public accountability. Although the state government tended to favor their link-person role,⁸ SHRC’s multi-sectoral approach to health was crucial to Mitanins fulfilling their other roles as service providers and advocates. Further, SHRC was able to institutionalize these roles through government guidelines and in CHW training (Nandi 2014).

The roles of Mitanins as service providers and agents of public accountability are mutually supportive. If the Mitanin provides services well, she is more acceptable as a leader. The Mitanin’s inter-sectoral identity matched the needs of community members and promoted her responsiveness towards them. This meant that community members were more likely to be satisfied with her work and to view her as a leader. For example, at the village level, Mitanins share leadership of Village Health Nutrition and Sanitation Committees⁹ (VHSNCs) with an elected Panchayat representative.¹⁰ 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). When village level action is not enough to address service gaps, Mitanins join other VHSNC members in planning meetings to bring together clusters of 10-20 villages; these actions are further aggregated at block¹¹ level through meetings of the program’s facilitation structure.

Demanding better healthcare services from public institutions is another significant part of Mitanins’ accountability work. Mitanins lead the organization of an annual *jan samwad* (public dialogue) in each of the 146 administrative blocks of the state. During these dialogues, they and other community leaders raise issues of gaps in services related to health and its social determinants, sharing testimonies, reports, and other forms of evidence which they have identified, documented and encouraged people to share. The participating officials are

asked by Mitanins to respond to the issues raised. Most of the dialogue events are attended by elected politicians—Members of Legislative Assembly, Members of Parliament, Presidents of District and Block Panchayats, and some state ministers. Mitanins strategically use the presence of political representatives to push the bureaucrats to pay attention and resolve people’s complaints (SHRC 2017).

The design of the Mitanin’s role is very broad, requiring her to learn a variety of skills, both technical and social. This creates opportunities for recognizing problems—including gaps in the delivery of public services—and developing new ways of redressing them. Examples of such learning include the adoption by VHSNCs of direct action strategies, instead of filling in report cards. For example, when Mitanins found that recording the performance of school meal and other nutrition programs was not enough to trigger change, they prepared action plans to intervene. When follow-up was slow despite such action planning, Mitanins started direct action: VHSNC members directly engaged the school authorities and pressurized them for improvements, rather than simply discussing issues in VHNSC meetings and await-

ing follow-up action from higher authorities. Other examples of new approaches include the use of street theater and participatory audits of the causes of mortality.

Learning from experience has also acted as a motivating factor for Mitanins, and the infusion of fresh agendas and methods for action helps rebuild their collective energy. At the program level, there is a conscious strategy to promote and utilize experiential learning. It takes further action on accountability by building on what was tried earlier. Action on health system accountability started with raising ‘local’ issues, for example, absence of nurses for immunization. Then Mitanins started raising issues of absence of staff and medicines in primary health centres. They used the learning from such action to raise issues of maternal deaths due to gaps in the inpatient services of public hospitals. This experience in turn was used by Mitanins to question corruption in private hospitals around state-funded health insurance. As their engagement with these issues increased, Mitanins were also able to point out some systemic gaps.

In terms of methods too, both program inputs and action by Mitanins evolved by using experience, from score



Mitanins taking a protest rally to head-quarters office of Sonhat block in Koriya district, 2009. Credit: © Sulakshana Nandi.

cards to *jan samwads* and street theatre. Campaigns were another way to promote action on the ground and they enhanced the scope for iterative adjustments in content and methods of action (Garg 2017). The experiential learning approach was also supported by the training design in the Mitanin program, which was not just modular but iterative. The curriculum was dynamic, responding to field-level feedback and also anticipating needs based on experience.

2. Community health workers can set agendas for advocacy on issues of accountability by building virtuous cycles of action and learning

Mitanins started earning cash incentives from the state government from 2007 onwards, receiving task-based payments rather than a fixed monthly wage. This payment structure served to highlight the continued misalignment of government priorities and community needs. The incentivized tasks represented the government's preference, discussed in the previous section, for Mitanins to emphasize their link-person role. Providing financial incentives to play this role meant encouraging Mitanins to bring more people to utilize a narrow range of specific public healthcare services for maternal care and immunization, at the expense of directly providing services to community members for the cure of common ailments. It also meant a reduced focus on skill-building, inter-sectoral action for improving services, and assuming leadership positions for demanding improvements in public services.¹² Nonetheless, the structure of task-based payments limited government control of Mitanins' work; a fixed monthly payment would have compelled the Mitanin to carry out any task listed under her job description and allowed higher officials greater influence over her.

Despite this incentivization of the link-person role, SHRC was able to continue to support Mitanins in their other roles by focusing the program's curriculum and supportive supervision primarily on community needs (see also Schaaf et al. 2018). They were also able to take advantage of the fact that the introduction of cash payments for Mitanins was accompanied by the language of community empowerment. Both were part of design of the National Rural Health Mission, which included the formation of VHSNCs as participatory bodies at village level, creating space for community action on the social

determinants of health. The SHRC used this national health mandate for community action, encouraging Mitanins to focus on social determinants. As discussed in the previous section, through VHSNCs, Mitanins prioritized accountability action on public services—availability and access to drinking water, food security programs, employment generation programs, and schools. This kind of inter-sectoral action elicited enthusiastic responses from communities and became the main agenda for collective action. Mitanins understood that for the largely impoverished population, food security is a necessary condition for improving health. Thus, they organized to demand better access to food security entitlements for communities. In some places, they were able to make linkages between health and peoples' control over natural resources, as reflected in their effective counter mobilization to state-sponsored deforestation in a tribal district (Nandi and Garg 2017).

Mitanins also received social recognition for their work as health service providers, delivering advice—for example, promoting breastfeeding—and curative care for common ailments, such as oral rehydration for diarrhea and local remedies for relief (Misra 2011). They also played a significant role in disease control for common communicable diseases such as malaria, tuberculosis and leprosy (Garg 2016). SHRC provided explicit support for this role and advocated with government for its expansion. Communities also appreciated the Mitanin because she accompanied them to public hospitals.

Mitanins' support for collective action around public services enabled them to achieve credibility as community leaders. Men also recognized Mitanins as leaders and approached them to solve community problems. For example, when wages for public works carried out under the National Rural Employment Guarantee Program were delayed, male and female workers approached Mitanins to help them secure their wages. Mitanins used a variety of strategies such as taking a collective delegation to the local elected government president and demanding timely payments, petitioning block or district civil servants, and raising the issue of delayed payments with political leaders. Such activities further encouraged the Mitanins to take up more inter-sectoral action.

Mitanins responding to community needs created a 'virtuous cycle' of action and learning. It gained them

recognition, increasing their motivation to take up more action. It also gained them credibility as leaders, which in turn enhanced their ability to set a wider agenda instead of being constrained by the agenda driven by cash-incentives from government.

3. Community health workers can build countervailing power at multiple levels

It is not uncommon for new governments to roll back or change programs introduced by previous governments, and like most government-run programs, Mitandin was vulnerable to this roll-back. The Mitandin program leadership defined survival as a central goal from the beginning. In order to reduce the threat of roll-back, the program was quickly expanded. The number of CHWs selected increased from 6,000 to 30,000 within the first year (2002), and to 54,000 the following year. The assumption behind this rapid expansion was that rolling back a large community-based program would prove to be difficult for any government, irrespective of the party in power. Mitandin used its size to overcome funding fluctuations, as well as a changing political environment, surviving major political changes in the state within its first two years. Gradually, the program won support from the new government in power. This was, in part, influenced by dramatic improvement in primary health indicators in Chhattisgarh, which were attributed to the program and its scaling-up (Sundararaman 2007).

Of course, as Mitandins became more active agents of public accountability, their actions generated a backlash from local elites and vested interests, and they were compelled to think and act strategically in order to survive. This involved building their countervailing power by bringing together their collective strength and that of their supporters from health committees. An individual Mitandin opposing corruption at the village level was supported by a state-wide network of Mitandins, as well as by allies at the district and state levels through the facilitation structure of trainers and SHRC. But beyond strength of numbers at the local level, Mitandins also focused on building networks across multiple levels of government. The significance of this multi-level engagement of government was that it bolstered their own voice and conveyed community demands higher up to decision-makers.

However, demanding accountability from healthcare facilities like hospitals was a higher order challenge. Hostility from health officials was particularly difficult because Mitandins were paid by the health department. SHRC protected Mitandins from such institutional backlash by helping frame appropriate state-level guidelines that made it difficult for government officers to remove or replace any Mitandin (Government of Chhattisgarh 2011), vesting this power in the community instead. Between 0.5 and 1% of all Mitandins are replaced annually as a result of this process.

The *jan samwads* also became a key forum for raising accountability of health service providers (SHRC 2017). In using them, Mitandins engaged one part of the state to resist the other: they organized for collective bargaining, engaged political elites in order to resist backlash from local health bureaucracies. Their credibility and visibility in the community also made them attractive for political leaders—keeping a Mitandin happy was an important electoral strategy (among others).

4. Community health workers can demand both rights for communities, and better working conditions for themselves

CHWs in India and many parts of the world are poorly paid and overworked. It is not surprising that their collective demands tend to focus on better payments and improvement in their working conditions. Mitandins chose different platforms to demand better working conditions for themselves in the form of more timely and better payments. Occasionally, they used *jan samwads* to draw attention to chronic delays in receiving incentive payments from the government. But more often, they utilized other tactics such as collective bargaining, petitioning, and protesting district level officials. While asking for better payments from the government, Mitandins took care to prevent any damage to their relationship with community. For example, they chose not to go on strike or stop work, which could have disrupted services. They organized a large number of high-visibility protests in district headquarters. These protests were effective in attracting the attention of various parts of the government and allowed Mitandins to utilize their political capital to bargain for better working conditions as well as aggregate community voice. Though their

payments are still inadequate, the trend from 2011 onwards shows growth and improvement.¹³

However, sustainable accountability action required that Mitanin collectives go beyond personal demands. The Mitanin program developed and promoted a set of collective platforms, from the village to the state level, to bolster joint participation of Mitanins and communities in an accountability agenda (Champa 2017). This strategy combined promoting interactions among Mitanins in meetings and training sessions, and promoting village-level collectives led by Mitanins. In both of the above fora, the agenda was focused on intersectoral needs of the community, which built on lessons from other socio-economic rights movements such as the Right to Food campaign and the Peoples' Health Movement. Gradually, Mitanins focused on building vertical linkages for accountability action. They undertook multi-level action from village to state level, with action at each level depending and building on action at other levels.¹⁴

5. 'Action-strategists' can create an appropriate state-civil society organization to facilitate community health workers' action

Jonathan Fox (2017) defines 'action-strategists' as "civil society thinkers and policy reformers who are directly engaged with transforming governance by promoting citizen action from both above and below." In this case, such actors were responsible for creating the SHRC, a semi-autonomous institution with a mixed state-civil society identity, to support the implementation of Mitanin and other measures or innovations to strengthen government health services (Nambiar and Sheikh 2016).¹⁵ The creation of SHRC was based on the recognition by these government and civil society action-

strategists that the health department would lack the capacity and temperament for building and sustaining a community-based program, and a specialized autonomous organization was needed for the role. The formal roles of SHRC, as listed in the state government guidelines, include the design of the training curriculum for Mitanins, capacity building, overall monitoring, preparing necessary guidelines, and advising government on ways to support the performance of Mitanins (Government of Chhattisgarh 2011).

A facilitation structure that straddles the state-society interface was created to coordinate the wide-ranging CHW action, which came to include networking and creating vertical linkages for accountability. This facilitation structure helped Mitanins to create an enabling environment for collective action and insulated them from bureaucratic control. Members of the facilitation structure, like Mitanins, perceived themselves to be community leaders as well as being implementers of the program. The use of the facilitation structure for mobilization as opposed to bureaucratic checks and balances was partly possible because of its links with the adult literacy movement; the initial leadership of the program was drawn from this movement, and they continue to advise SHRC even today (Nambiar and Sheikh 2016). This structure embodied movement sensibilities focused on strengthening accountability and systemic change (or changing the practices of rural public health agencies) and contributed to the dynamic nature of the learning for sustainability approach. The program combined supervisory and capacity-building roles so that the administrative practice of this support structure bureaucracy is moderated by its mentoring role. The stewardship role of SHRC, facilitated by its relative autonomy, is seen as central to activism becoming an integral part of the role and practice of Mitanins (Nambiar et al. 2015; Nandi 2014; Schaaf et al. 2018).

III. Conclusion



This note argues that it is important to examine CHW programs through an accountability lens. Keeping in mind the power dynamics that often undercut the CHW's ability to act as an agent of accountability, this note shows how the Mitanin program prioritized building in learning as a key enabler for sustained action on public accountability by the health system to the people who use and access public health services. The program enabled actors in state and civil society to design institutions and processes appropriate for accountability to emerge and be sustained. This approach

to integrating learning and action required anticipating the challenges and building counter-strategies and continuously updating the design and practice to ensure sustainable action for public accountability.

The Mitanin program shows that a focus on iterative learning that is observant of, and committed to managing, the essential tensions that are inherent in the role of community health workers is the key for sustainable accountability.



Mitanins after a group discussion in front of a Mitani's house in Durgkondal block of Kanker district, 2012. Credit: © Sulakshana Nandi.

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Endnotes

1. 'Mitandin' means 'friend' in Chhattisgarhi language. It is a term borrowed from a local cultural tradition of creating life-long bonds of friendship.
2. For discussion on the concept of boundary organizations, see Gustafsson and Lidskog (2018).
3. By 'public accountability', we mean accountability of the health system to the people who access and use public health services, and not to higher officials or external actors such as donors.
4. The first author has been associated with the Mitandin program for 15 years.
5. See Garg (2017) for a description of the evolution of the program's accountability work.
6. For example, both Mitandins and the members of the communities they work in rely on agriculture as their main source of income, work as daily wage laborers, and fall under the national poverty line (Misra 2011).
7. The Adult Literacy Movement started in Kerala state in the late 1980s. It created a combination of district authorities and social activists working jointly to spread literacy. A significant feature was a social mobilization campaign using local cultural troupes (Sundaraman 1996; Sundaraman 2003).
8. Strong resistance exists within health bureaucracies and the formal medical profession to empowering CHWs with skills and medicines to act as effective service providers (Werner 1981).
9. In 2007, VHSNCs were introduced by the national government under its National Rural Health Mission as a participatory component for the health education of communities, and to improve sanitation in villages.
10. Panchayats are statutory elected village councils in India 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.
11. A block is a rural administrative unit in India. In central India, it usually has a population of around 50,000-200,000, spread across between 100 and 200 villages.
12. The Mitandin program learned strategies in this regard from India's Right to Food campaign (Garg 2006 and 2013).
13. The average payment was INR 200 in 2011 (Misra 2011) which increased to INR 2300 in 2018.
14. For more on strategies for 'connecting the dots' in accountability ecosystems, see Fox and Halloran (2016).
15. See also Sundaraman (1996) and Sundaraman (2003).

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School of International Service
4400 Massachusetts Ave NW
Washington, DC 20016
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