THE ROLE OF COMMUNITY HEALTH WORKERS (CHWs) IN ADDRESSING SOCIAL DETERMINANTS OF HEALTH IN CHHATTISGARH, INDIA

Sulakshana Nandi

A mini-thesis submitted in partial fulfillment of the requirements for the degree of Masters in Public Health at the School of Public Health, University of the Western Cape

Supervisor: Prof. Helen Schneider

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KEYWORDS

- Community Health Worker
- Mitanin
- ASHA
- Social determinants of health
- Nutrition
- Violence against women
- Primary Health Care (PHC) Approach
- Qualitative research
- Case study method
- India
- Chhattisgarh

DECLARATION

I declare that the work presented herein; ‘Role of Community Health Workers (CHWs) in addressing Social Determinants of Health in Chhattisgarh, India’, is original and that it has not been submitted for any degree or examination in any other university or institution for the award of a degree or certificate and that all sources of information and data used or quoted have been duly indicated and acknowledged.

Full Name: Sulakshana Nandi

Signature: Dated: 25th May 2012

LIST OF ACRONYMS

ANM	Auxiliary Nurse and Midwife
ASHA	Accredited Social Health Activist
BC	Block Coordinator
CHW	Community Health Worker
CSDH	Commission on Social Determinants of Health
DC	District Coordinator
DRP	District Resource Person
ICDS	Integrated Child Development Services
IMR	Infant Mortality Rate
MDM	Mid Day Meal
MNREGS	Mahatma Gandhi Rural Employment Guarantee Scheme
MT	Mitanin Trainer
NRC	Nutritional Rehabilitation Centre
NRHM	National Rural Health Mission
PDS	Public Distribution System

PHC	Primary Health Care
SAM	Severe Acute Malnutrition
SHG	Self Help Group
SHRC	State Health Resource Centre
SRS	Sample Registration System
VHSNC	Village Health, Sanitation and Nutrition Committee
VHW	Village Health Worker
WHO	World Health Organisation

DEFINITIONS OF KEY TERMS

Term	Definition
ASHA	Name given to the CHW under the programme of the same name, started as part of the National Rural Health Mission in 2005
Block	A Block is an administrative unit below the district. Many villages and a few urban units make up a Block.
Block Coordinator	In the Mitanin Programme, there are two Block Coordinators coordinating the programme in a Block.
Cluster	A group of around five to ten Mitanins constitutes a cluster. Monthly meetings of the Mitanins are held at the Cluster level.
District	The State is divided into administrative units called districts. Districts in turn are made up of Blocks.
District Coordinator	One District coordinator looks after the Mitanin Programme in around five Blocks.
Gram Sabha	General Body consisting of all adults in the village, lowest unit of local governance
Hamlet	A rural habitation, A village is made up of one or more hamlets or habitations, which are geographical entities with a cluster of houses, usually more homogeneous than bigger units
Mitanin	Literally meaning 'friend' in language of Chhattisgarh state, Mitanin is the name given to the Community Health Worker (CHW) in the CHW programme of the same name, which

	started in 2002 in Chhattisgarh State.
Mitanin Trainer	Mitanin Trainer is responsible for imparting training and supporting the Mitanin in her work. One Mitanin Trainer usually looks after a set of 20 Mitanins.
NRHM	National Rural Health Mission (NRHM), a Comprehensive programme for Health started in India from 2005
Panchayat/Village council	Village Council or the *panchayat* is the lowest elected body for local governance. One village council may cover more than one village.
Panch	Elected member of the village council
Sarpanch	Elected Head of the village council
Scheduled Area	These are areas with sizable proportion of tribal population that are identified in Schedule V of the Indian Constitution.
Self Help Group	Group of more than ten members, usually women, who have come together mostly for activities like savings and credit or running an enterprise.
Tribe/Scheduled Tribe (ST)	Tribes or STs are indigenous communities as identified by the Government as per procedures laid down in the Constitution
Village Health, Sanitation and Nutrition Committee	Village level committee formed under NRHM, to plan and act on health and nutrition issues.

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TABLE OF CONTENTS **PAGE**

Title Page	i
Keywords	ii
Declaration	iii
List Of Acronyms	iv
Definitions of Key Terms	vi
Acknowledgements	viii
Table of Contents	ix
Abstract	xv
CHAPTER 1. DESCRIPTION OF THE STUDY	**1**
1.1: Introduction	1
1.2: Rationale for undertaking this study	2
1.3: Study Setting	3
CHAPTER 2. LITERATURE REVIEW	**10**
2.1: Social determinants and health inequity	10
2.2: Community Health Workers addressing social determinants	12
2.2.1: Role of CHWs in action on social determinants	14

2.2.2: Factors influencing action on social determinants 19

2.2.3: Process of action on social determinants 23

2.3: The Mitanin Programme and action on social determinants 24

2.4: Evidence on outcomes of the Mitanin Programme 29

CHAPTER 3. RESEARCH DESIGN AND METHODOLOGY 33

3.1: Study Aim 33

3.2: Objectives 33

3.3: Methodology 33

3.3.1: Study Design 33

3.3.2: Justification for selection of the study design and research methods 33

3.3.3: Study Population 34

3.3.4: Definition of a Case and Case Selection 35

3.3.5: Data Collection 37

3.3.5.1: In depth Interview 39

3.3.5.2: Group Interview 39

3.3.5.3: Review of documents 40

3.4: Analysis 40

3.5: Trustworthiness 42

3.6: Limitations 44

3.7: Ethical Considerations 45

4. RESULTS **48**

4.1: Socio-economic, political and programme context 48

4.2: Case study on Mitanin's action on nutrition in Durgkondal Block of Kanker District 51

4.2.1: Situation of nutrition before Mitanins started working on it 55

4.2.2: The catalysts for Mitanins to start working on issues of nutrition 58

4.2.3: The Mitanin's role 64

4.2.4: Process of taking action on nutrition 66

4.2.5: Changes that have come about in nutrition 74

4.2.6: Challenges faced 75

4.3: Case study on Mitanin's action on violence against women in Manendragarh Block of Koriya District 77

4.3.1: Situation of violence against women 78

4.3.2: Catalysts for Mitanin's action on violence against women 81

4.3.3: The Mitanin's role 87

4.3.4: Process of taking action on violence against women 89

4.3.5: Changes that have come about in situation of violence against women 96

4.3.6: Challenges faced 101

CHAPTER 5. CROSS LEARNING AND DISCUSSION **103**

5.1: What was situation before and what changed? 103

5.2: What were the catalysts for action? 105

5.2.1: Definition of health and role of the Mitanin in the programme 105

5.2.2: Selection 106

5.2.3: Training and on going support 108

5.2.4: Accountability and payment 110

5.2.5: Significance of the Mitanin's work to the community 112

5.2.6: Environmental factors 113

5.3: What role has emerged for the Mitanins? 114

5.3.1: Role as a change agent within the community 115

5.3.2: Role as an advocate for the community 116

5.4: How did the changes come about? 117

5.5: Challenges faced 118

6. CONCLUSIONS AND RECOMMENDATIONS **121**

6.1: Conclusions 121

6.2.1: Recommendations for the Mitanin Programme 124

6.2.2: Recommendations for the ASHA Programme towards addressing social determinants of health 126

6.2.3: Recommendations about the design of CHW programmes to better address social determinants 127

6.2.4: Future research avenues 128

REFERENCES **129**

LIST OF APPENDICES

Appendix 1: Participant Information Sheet 140

Appendix 2: Record of Informed Consent to Participate in Individual Interview 143

Appendix 3: Record of Informed Consent to Participate in Group Interview and Confidentiality Binding Form 146

Appendix 4: Interview Guide: CHW Interview 150

Appendix 5: Community Group Interview Guide 152

Appendix 6: Training Rounds in the Mitanin Programme 153

List of Tables

Table 1: Socio-Economic Profile of Chhattisgarh State 4

Table 2: Studies on CHWs and social determinants reviewed 15

Table 3: Improvements in anemia and breastfeeding practices between 1998/99 and 2005/06 30

Table 4: Number of Individual and Group Interviews undertaken in both case studies 38

Table 5: Geographical, and demographic characteristics of the two Blocks 48

List of Figures

Figure 1: Map of India and Chhattisgarh showing districts under study (Kanker and Koriya) 6

Figure 2: CSDH Framework for understanding the major categories of determinants and the processes and pathways that generate health inequities 11

Figure 3: Mitanin Programme Structure 50

Figure 4: Explanatory Framework for Mitanin's action on social determinants 122

ABSTRACT

One of the biggest challenges facing India today is the dismal state of social determinants of health leading to increasing health inequity. The Mitanin Programme is a government Community Health Worker (CHW) programme in Chhattisgarh State which started in 2002 and aimed to undertake family level outreach services, community-organisation building and social mobilization on health and its determinants along with advocacy for improvement in the health system through women volunteers in every hamlet. Lessons from this programme led to the formulation of a countrywide CHW programme called the ASHA (Accredited Social Health Activist) programme. Recent evaluations of the Mitanin Programme have shown that along with improvements in health and mortality indicators, and improved access to health services especially of women and children, Mitanins have been involved in action on social determinants and health inequity. Although it has been recognised that both the ASHA and Mitanin programmes have been able to address certain social determinants, there still remains a big gap in terms of documenting such action in depth.

The aim of this research was to describe the role of Community Health Workers, in the Mitanin Programme, in addressing social determinants of health in Chhattisgarh State of India, with the view to identify the pathways for strengthening and making recommendations on this aspect of the CHW's work for existing or future CHW programmes.

A comparative case study design using qualitative research methods was adopted for the study, with the sample comprising of two case studies of action on social determinants by CHWs. The definition of a case was 'successful action by a CHW

(Mitanin) or team of CHWs (Mitanins) on nutrition or violence against women in the village or cluster of villages for which the CHW/s are responsible'. The sampling of the cases followed the 'replication logic', that is, examination of similar cases to draw general lessons. Data collection was undertaken through In-depth Individual Interviews and Group Interviews with CHWs, community members and programme staff that participated with the CHWs in, and also benefitted from, their action on social determinants. Respondents were identified through a process of snowball sampling. Seventeen in-depth interviews and ten group interviews (total 27) were conducted as part of the study.

A broad conceptual framework of the factors facilitating and constraining the action on social determinants by the CHWs, along with the pathways for action on social determinants by CHWs and their role, was developed at the start of the research. The analysis was done using this conceptual framework, which was refined during analysis, resulting in an explanatory framework. The analysis was two-fold. Firstly, both cases were analysed and written up separately and then they were analysed together in order to draw cross case conclusions. Thematic analysis was undertaken.

Ethical Clearance was obtained from the UWC Senate Research Committee and permission was obtained from the State Health Resource Center, the body coordinating the Mitanin Programme in Chhattisgarh. A Participant Information Sheet and Informed consent forms for both the individual and the group interviews were prepared and administered. The form for the group interview included a confidentiality-binding clause.

The study showed that the Mitanins in Durgkondal and Manendragarh (the Blocks under study) had effectively and successfully addressed the issues of nutrition and

violence against women as social determinants, in a manner visualized in the initial programme documents. Despite threats to the autonomy of the programme, pressures to formalise the Mitanin's role, and backlash from vested interests, such action remained sustained, nearly ten years since the start of the programme.

The process of action on social determinants was very similar in both cases and followed processes of community mobilization and social action within the community and vis-à-vis the government and service providers. A key vehicle for action was local political structures, namely village councils, which appear to have been revitalized with more equal gender representation as a result of Mitanins' intervention.

The study identified a number of factors underpinning successful action on social determinants. It illustrated the significance of the 'intent' of the programme, and how this was carried through into all aspects of programme design and processes. The way the Mitanin's role was visualised at the beginning of the programme got reflected in every aspect of programme implementation like selection, training, supervision, support, remuneration, and accountability. Also important was the role of the Mitanins, their identification with ordinary village women, and how they emerged as 'agents of change' and as 'advocates for the community'. Community members consider her as someone who is knowledgeable, just, and available, who articulates the demands and defends the rights of the poor and marginalized.

Being a qualitative study, the results are not narrowly generalisable to the 'study population' of the Mitanin programme as a whole; however, the explanatory framework that has emerged from the study may be used for 'analytical generalisation', in raising general lessons for programmes in similar contexts.

The study suggests lessons for further development of the Mitanin and ASHA Programmes in India, and more generally, CHW programmes interested in addressing social determinants and visualising an 'activist' role for the CHW. Key among these are that CHW programmes need to, from the beginning, be formulated within the framework of comprehensive primary health care and with the intent of addressing the social determinants of health. CHWs themselves need to be supported in a sustained manner and accorded some degree of autonomy to successfully act as a change agent and as an advocate for the community.

CHAPTER 1. DESCRIPTION OF THE STUDY

1.1: Introduction

The Commission on Social Determinants of Health (CSDH) unequivocally states that poor health status and growing health inequities within and between countries are reflections of inequity in social, economic and political processes (CSDH, 2008). This was a reiteration of the principles of the Primary Health Care (PHC) approach articulated at the Alma Ata Conference in 1978, which is based on equity, self determination and justice, and which advocates a strategy of providing healthcare services along with addressing the social, economic and political determinants of health (Szreter, 2008, Werner & Sanders, 1997). Community health workers (CHWs) have been considered an integral part of the PHC approach (Werner & Sanders, 1997). However, their role as advocates and mouthpiece for the community to fight inequities and as change agents has remained controversial even among proponents of the PHC approach (Bender & Pitkin, 1987; Lehmann & Sanders, 2007). The narrowing down of the PHC approach and two decades of market-driven policies and forced reduced social sector spending (Werner & Sanders, 1997; Lawn *et al.,* 2008; Walsh & Warren, 1979), further dealt a blow to this. As Werner and Sanders (1997:19) lament, these “agents of change” were pushed to the lowest rung of the health system providing limited curative services as “lackey”, not “liberator”.

Nevertheless, various movements for PHC and programmes by countries committed to PHC ensured that the vision and hope for ‘Health for All’ remains (CSDH, 2008). Internationally there are a number of instances/programmes in which CHWs have played a role in helping to address issues of inequity and act upon the social

determinants of health (Ingram *et al*, 2008; Lehmann & Sanders, 2007; Spencer *et al*, 2010).

1.2: Rationale for undertaking this study

In India, one of the biggest challenges today is the dismal state of social determinants of health leading to increasing health inequity (Deaton & Dreze, 2002; Joe *et al*, 2008; Sen *et al*, 2002). The mismatch between fast economic growth and stagnation in health along with pressure from left parties, led to the formation of the National Rural Health Mission (NRHM) in 2005 (NRHM, 2005a; Rao, 2009). NRHM is accepted as an example of Comprehensive Primary Heath Care with Community Health Workers (ASHAs) as one of its main components (Lawn *et al*, 2008). Prior to the NRHM, the government in the State of Chhattisgarh in 2002 initiated a CHW programme, called the Mitanin Programme. The Mitanins are women volunteers and the Mitanin Programme aims to undertake family level outreach services, community-organisation building and social mobilization on health and its determinants along with advocacy for improvement in the health system (SHRC, 2003a; Sundararaman, 2007), and in many ways follows the PHC approach. The current research focuses specifically on the Mitanin Programme being implemented in Chhattisgarh and not the countrywide ASHA Programme.

Though it has been recognised that CHWs in both the ASHA and the Mitanin programmes have been able to address certain social determinants (NHSRC, 2010; Sanders, 2008, Schaay & Sanders, 2008; Sundararaman, 2007), a gap remains in terms of documenting such action in depth. As a result, the pathways for strengthening this aspect of the CHW's work are not clear. Beyond India, there is also limited research and documentation on the experiences of CHW programmes in

addressing social determinants in developing countries (Lehmann & Sanders, 2007). The current research hopes to fill this gap to a small extent by giving insights into the process, including challenges and facilitating factors, of action on social determinants by CHWs of the Mitanin Programme in a rural and tribal area of India. The findings could contribute to modification or strengthening of the programme design of CHW programmes in the context of addressing social determinants. This research will also be useful to the current ongoing debate on the future role of the CHWs in both the Mitanin and ASHA Programmes.

The author has been involved with both the Mitanin and the ASHA Programmes since their inception. She was a Governing Board Member of the State Health Resource Center, Chhattisgarh, which is the facilitating agency for the Mitanin Programme and has also worked directly with Mitanins in Koriya district. She has been contributing to the knowledge base and debates on role of CHWs, action on social determinants and public health systems as part of the People's Health Movement in India. This provides an opportunity for the current research to impact upon future planning and design of the existing CHW programmes both at the National and the State levels.

1.3: Study Setting

Chhattisgarh, which came into being in the year 2000 is the 10th largest State in India with an area of 135,191 km^2. Once a part of the central Indian state of Madhya Pradesh, it is located in the southeastern part of central India (Figure 1). With a total population of more than 25 million (Census 2011), it is the 17th largest State of the country by population, and has 27 districts. Around 41% of its total geographical area comes under forests (FSI, 2011). The population is mostly rural with only 22% of the households living in urban areas, (NFHS, 2007). Nearly 86% of the households in the

State belong to marginalized and socially excluded groups out of which 32% are from tribal communities (Census, 2001).

The public health system in Chhattisgarh currently has in place, around 4741 Health Sub-Centers, 721 Primary Health Centers and 136 Community Health Centers in addition to 18 District Hospitals and three Medical Colleges training health professionals.

Though it has an abundance of minerals and other natural resources, Chhattisgarh is considered one of the most 'backward' States with the second highest proportion of poor amongst all Indian States. Certain Socio Economic Indicators of Chhattisgarh are given in the Table 1.

Table 1: Socio-Economic Profile of Chhattisgarh State

	Indicator	Measure	References
1	Population (in thousands)	25,540,196	Census, 2011
2	Female population (in thousands)	12,712,281	Census, 2011
3	Total Fertility Rate (number of children likely to be born to a woman)	3	http://jsk.gov.in
4	Sex Ratio (number of females per 1000 males)	991	Census, 2011
5	Child Sex Ratio (number of females below age of six per 1000 males below age of six)	964	Census, 2011
6	Infant Mortality Rate (deaths under one year of age per 1000 live births during the same peiod)	52	SRS, 2011

7	Maternal Mortality Ratio (number of women who died during pregnancy or within 42 days of termination of pregnancy per 100,000 live births, during a year)	269	SRS, 2011
8	Mean Age at marriage (in years)	Male- 22.8 Female- 18.9	DLHS-3
9	% of girls who got married before 18 years of age	21.3%	DLHS-3
10	Literate Female Population (Above 7 years of age) as percentage of total female population (Above 7 years of age)	60.59%	Census, 2011
11	Literate Male Population (Above 7 years of age) as percentage of total male population (Above 7 years of age)	81.45%	Census, 2011
12	Percentage of girls, aged 6 to 11 years, attending Schools	81%	NFHS-3
13	Poverty Ratio (proportion of the population identified as poor as per government definition)	49.4%.	Planning Commission, 2009

The study was undertaken in Durgkondal block of Kanker district and Manendragarh block of Koriya district. Though geographically wide apart, with Kanker being in the south and Koriya being the northern-most district of Chhattisgarh (see Figure 1), they

share similar socio-economic and geographical features. Both blocks are tribal blocks and the communities depend on wage labour and forests for their livelihoods. However, though parts of Kanker are affected by conflict between the state and extremists, Koriya is currently not under such conflict. Being forested and remote areas, the state of the public health system is very similar in both. There are serious issues in access to healthcare (PHRN, 2010). The formal private sector in health is concentrated in a few of the bigger towns.

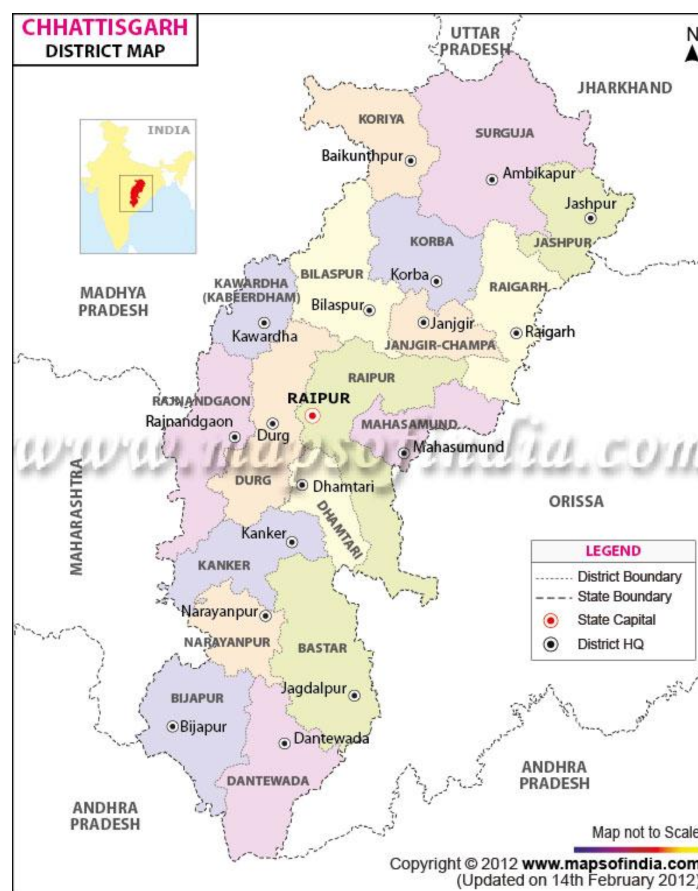

Figure 1: Map of India and Chhattisgarh showing districts under study (Kanker and Koriya)

The Mitanin Programme is a part of the health sector reforms initiated by the Chhattisgarh Government soon after the formation of the new state of Chhattisgarh in 2000. The newly formed state inherited many health challenges. The public health

system was fraught with problems like poor health infrastructure, lack of human resources, lack of funds, alienation from the community, especially in rural areas and a focus on treatment rather than prevention (SHRC, 2003a). The rural poor therefore were not able to access the public health system and instead were at the mercy of un-trained and unregistered medical practitioners resulting in loss of money and health (SHRC, 2003a). High levels of anemia and malnutrition exacerbated the situation resulting in high mortality of children due to diarrhea, malaria, and measles; and of women due to lack of services during pregnancy and childbirth. The state also had high prevalence of leprosy and tuberculosis (SHRC, 2003a). Therefore, health reforms were at the forefront of the political agenda at the highest levels and were spearheaded by progressive bureaucrats and civil society familiar with the PHC approach. The leverage enjoyed by the Mitanin Programme is seen in the fact that even after the change of government in the 2003 elections, when the opposition party came into power, it has remained high on the list of political priorities. In order to provide ongoing support to the reform agenda and facilitate the CHW programme, the State Health Resource Center (SHRC), "an additional technical capacity" to the health department, was set up by a joint memorandum between the Government of Chhattisgarh and a civil society organization, Action Aid (SHRC, 2003a: 39). In tune with SHRC's agenda, an appropriate candidate, Dr. Sundararaman[1], having a background in medicine along with experience in health policy, CHW programmes and social mobilisation, was selected to head it.

Since its inception, the Mitanin Programme sought to demonstrate the "empowerment concept of people's participation" in the field of public health (SHRC, 2003a:11).

[1] Dr. Sundararaman was a professor in JIPMER (medical college), Pondicherry, founding member of the People's Science Movement and an active member of the People's Health Movement.

The Mitanin's role was visualized to be much broader than a CHW providing health care or linking the community to health services. She was seen to facilitate a social process of empowerment leading to social and economic justice (SHRC, 2003a). She was expected to become "a true guide to the community of the habitation in all their endeavors" (SHRC, 2003a: 13). At the outset of the Programme therefore, she was seen as a volunteer who was to be selected by and accountable to the community (SHRC, 2003a). She was not to be given any honorarium by the government and it was visualized that she would receive monetary compensation for her time through community-based mechanisms (SHRC, 2003a). However, such mechanisms did not emerge and since 2005 under the National Rural Health Mission, the Mitanins have been receiving incentives for various tasks like gathering children for immunization, and referring pregnant women to health facilities for delivery. They have also started to get compensation for loss of livelihood whenever they are called for trainings (NRHM, 2005b).

Now more than 10 years into the programme, evidence shows that the Mitanin programme has led to improvements in health indicators, increased access to health services for the poor, and action on various social determinants. For example, the Mitanin programme has achieved an increase in initiation of breast feeding, decrease in infant mortality and rights based collective community action for securing tribal livelihoods, demanding entitlements, action against corruption and increase in political participation and empowerment of rural women (Sanders, 2008, Schaay & Sanders, 2008; Sundararaman, 2007, Rajshekhar, 2010). Lessons from the Mitanin progamme helped in the formulation of a countrywide CHW programme called the ASHA (Accredited Social Health Activist) Programme under the National Rural Health Mission in 2005 (NRHM, 2005b). The recent evaluation of the ASHA

programme has found, however, that although in some states the ASHAs are working on social determinants, this remains a weak component of the programme (NHSRC, 2010).

Thus, the Mitanin Programme, where Mitanins have emerged as an ‘agent of social change’ and an ‘advocate for the community’, provides an appropriate setting to explore the role of CHWs in helping communities to address the social determinants of health and the processes that lead to such action.

CHAPTER 2. LITERATURE REVIEW

The literature review first seeks to understand the concepts of social determinants and of CHWs as outlined in literature. Subsequently, experiences of CHWs addressing social determinants of health are discussed, including the specific roles of the CHW, influencing factors for such action and the processes followed. Finally, existing literature on the Mitanin Programme is reviewed in which the origin of the programme, role of the Mitanins, action on social determinants by the Mitanins and outcomes of the progamme are explored.

2.1: Social determinants and health inequity

In recent times the various processes of the Commission on Social Determinants of Health (CSDH) have influenced the understanding on social determinants and health equity. The Discussion paper for the Commission on Social Determinants of Health integrates various perspectives and approaches to defining these concepts (CSDH, 2007). Action on social determinants is described as a 'political process' involving both disadvantaged groups and the state. As it involves a struggle for control over power and resources, it may be contentious (CSDH, 2007). It outlines four types of power as per the feminist perspective - Power over (ability to influence or coerce); Power to (organize and change existing hierarchies); Power with (power from collective action); and Power within (power from individual consciousness) (CSDH, 2007).

The CSDH provides a comprehensive framework for understanding the social determinants of health, the pathways and its impact on health inequity (CSDH, 2007). As illustrated in Figure 2, the framework includes the structural and the intermediary determinants of health (CSDH, 2007: 48).

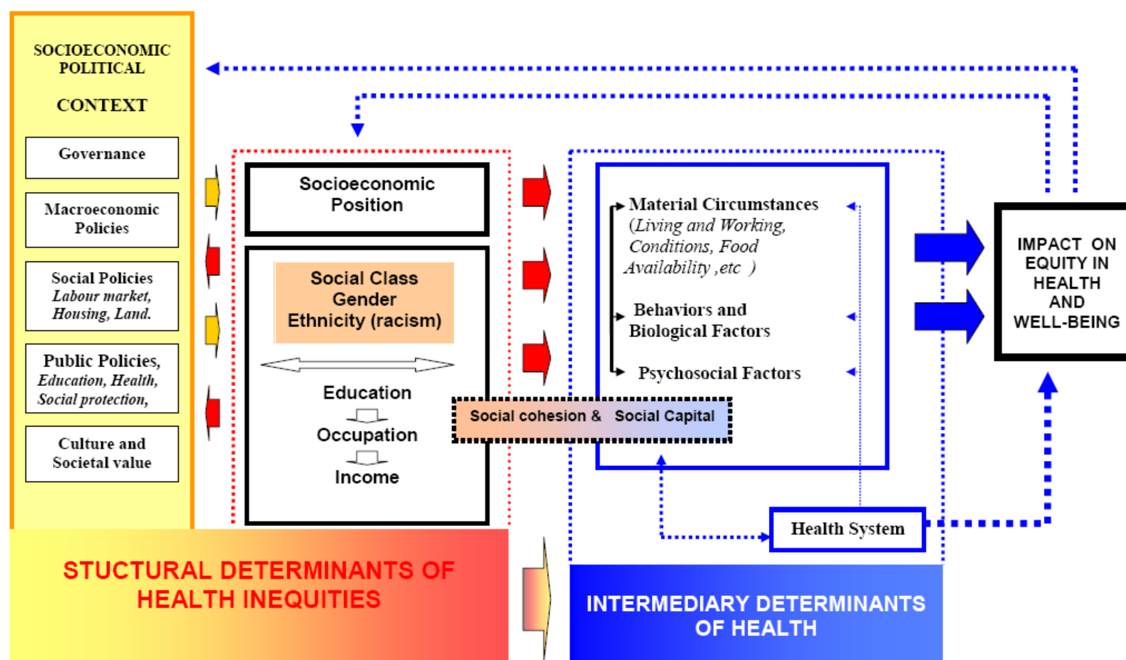

Figure 2: CSDH Framework for understanding the major categories of determinants and the processes and pathways that generate health inequities (CSDH, 2007: 48)

The People's Health Movement-India in responding to the analysis by CSDH has described gender, access to water, environmental pollution, marginalization/social exclusion, war/defence, food and nutrition security, trade, livelihoods/employment as components of social determinants of health (PHM-India, 2005).

A number of authors have described the nature of action required to address social determinants. The 'nutcracker approach' has been proposed by Baum (2007) in the action on social determinants and social equity, which involves a combination of political action, policy making from above and bottom up action by civil society and community.

Loewensen (2009) states the importance of empowerment as a social determinant and states that, "health systems often reflect the inequalities in power and wealth in

society, but they can also confront them". She quotes Wallerstein (2006) who concluded that "interventions that strengthen empowerment:

- Promote better health through individual empowerment outcomes and action on the structural determinants of health, or by encouraging greater health care use;
- Can address health inequity by generating preferential gains for socially disadvantaged groups, either by impacting on structural factors or by being implemented with these groups, and
- Have, for women specifically, resulted in greater psychological empowerment and autonomy, and substantially affected a range of health outcomes, where most closely integrated with the economic, education and/or political sectors."

The 2008 World Health Report marking the 30th anniversary of the Alma Ata Declaration on Primary Health Care distinguishes between conventional healthcare and people-centered primary care. It states that in the people-centered approach, people are partners in managing their and their community's health and it has to tackle the determinants of ill health (WHO, 2008).

2.2: Community Health Workers addressing social determinants

The concept of CHWs has been around for over 50 years (Lehmann & Sanders, 2007). The WHO Study Group defines CHWs as follows:

"Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not

necessarily a part of its organization, and have shorter training than professional workers" (Lehmann & Sanders, 2007:3).

The roles and activities of CHWs have varied across different programmes and countries (Lehmann & Sanders, 2007). Lehmann and Sanders (2007) make a differentiation between generalist and specialist CHWs. Review of CHW programmes show that specialist CHWs have been used in aspects of mother and child health, TB and HIV/AIDS care, malaria control, treatment of acute respiratory infections (Lehmann & Sanders, 2007). The generalist CHW performs a wide range of activities which includes preventive, promotive and curative services across issues of drinking water, nutrition, sanitation and community development in addition to maternal and child health, disease control, and surveillance (Lehmann & Sanders, 2007).

Lehmann and Sanders (2007: 5) write, "the early literature emphasizes the role of the village health workers (VHWs), which was the term most commonly used at the time, as not only (and possibly not even primarily) a health care provider, but also as an advocate for the community and an agent of social change, functioning as a community mouthpiece to fight against inequities and advocate community rights and needs to government structures: in David Werner's famous words, the health worker as "liberator" rather than "lackey"". They give examples of the VHW programmes in Tanzania and Zimbabwe, which followed this rationale in their initial years (Lehmann & Sanders, 2007). In the present research the definition of CHW is akin to this articulation.

Similarly, Krishnamurthy & Zaidi (2005:3) in their note on the 'essential elements and enabling environments' of CHW programmes, surmise that the role of CHWs falls between two paradigms, one focussed on empowerment and social activism and the other on linking the community and formal systems and "community management function". This has consequences for the role, training and support accorded to the CHWs. They are of the opinion that in the context of poor communities and weak health systems, it is possible and essential to integrate both these approaches.

Review of literature on the role of CHWs as a 'liberator', in impacting social determinants and health equity was undertaken by the researcher in order to understand the existing knowledge and experiences on this aspect. Unfortunately, there are few studies and documents exploring this role of CHWs.

One reason for the dearth of such research could be that there seem to be fewer CHW programmes that articulate and visualize this role for CHWs. Another factor as articulated by Ingram *et al* (2008) is that due to the nature of available funding, health programmes and their evaluations are compelled to focus on individual health outcomes. Therefore, even when CHWs have brought about social change and mobilised communities on determinants of health, it is rarely recognized or documented.

2.2.1: Role of CHWs in action on social determinants

Experiences with community health worker (CHW) action on social determinants have been documented across the world (Werner, 1977; Bender & Pitkin, 1987; Schultz *et al*, 2002; Becker *et al*, 2004; Farquhar *et al*, 2005; Krishnamurthy & Zaidi, 2005; Wallerstein, 2006; Lehmann & Sanders, 2007; Prasad & Muraleedharan, 2007;

Ingram *et al*, 2008; Perez & Martinez, 2008; Labonte, 2010; van Ginneken *et al*, 2010). Key sources identified and reviewed are listed in Table 2.

Only those studies have been included which have studied CHW programmes in the context of various aspects of social determinants. In the review the researcher first explores the role of CHWs as given in literature, followed by examining the factors, both programmatic, like programme design, selection and training, and environmental, which have led to CHWs' addressing social determinants of health. It concludes with examining the process of action as described in various studies.

Table 2: Studies on CHWs and social determinants reviewed

Reference	Country/countries (programme)	Setting	Action on social determinants
Werner, 1977	Latin America	Rural and remote populations	Various socio-economic and political determinants
Bender & Pitkin, 1987	Costa Rica, Nicaragua, Columbia	Rural, underserved populations	Various
Schultz *et al*, 2002	U.S., Detroit (ESVHWP)	Migrant, African American communities	Stress and its determinants

Becker *et al*, 2004	U.S., Philadelphia	Pregnant women and young mothers from low income groups	Empowerment
Farquhar *et al*, 2005	U.S. (Poder es Salud/Power for Health)	African American and Latino communities	Health inequity, social capital, other social determinants
Krishnamurthy & Zaidi, 2005	India (Review of CHW programmes)	Rural communities	Various
Wallerstein, 2006	Review of empowerment programmes world wide	Various, including socially excluded and disempowered populations	Empowerment
Lehmann & Sanders, 2007	Review of 250 documents on CHW programmes world wide	Various	CHWs as advocates and agent of change
Prasad & Muraleedharan, 2007	Review of 101 studies world	Various	Empowerment, self esteem, social

	wide		inequity
Ingram *et al*, 2008	USA, Arizona Arizona Community Health Outreach Worker Network (AzCHOW)	Hispanic and American Indian CHWs	Advocacy, poverty, employment, housing, and discrimination
Perez & Martinez, 2008	U.S.	Migrant and other vulnerable	Advocacy, social justice and policy
Labonte, 2010	Worldwide	Less advantaged groups	Health equity, governance
van Ginneken *et al*, 2010	South Africa	CHW programmes in late apartheid period	Political activism

Examining the evolution and status of CHW programme in three Latin American countries within the framework of PHC (Primary Health Care), Bender and Pitkin (1987) emphasised that the CHWs should be able to respond to the health needs of the community, even to issues not directly related to health. By doing so the health workers are able to illustrate the importance of such work and how this relates to health. The authors found that the nature of CHW programmes emerged as per the socio-cultural, economic and political situation of the country and its people. They

bring out the contradiction between two approaches to roles visualized for the CHW vis-à-vis the government and the political sphere. They state that the first approach is that of the CHWs primarily challenging the existing power structures as a "revolutionary", and the second, more in line with the WHO and supported by the authors, is that of working for social change, without challenging the health system, rather working within it (Bender and Pitkin, 1987).

Various authors studying CHW programmes in the U.S. have commented on the significance of the CHWs' work among migrant, vulnerable and marginalised populations (Farquhar *et al*, 2005; Ingram *et al*, 2008; Perez & Martinez, 2008). They find that the CHWs play the role of community advocates and provide leadership to address a number of social determinants, "including economic, social, environmental, and political rights" (Perez & Martinez, 2008:11), "structural issues such as poverty, employment, housing, and discrimination" (Ingram *et al*, 2008:417), and health disparities (Farquhar *et al*, 2005).

Van Ginneken *et al* (2010) who undertook an historical analysis of the emergence of CHW programmes in the late apartheid period in South Africa, through oral history interviews, found that in all programmes there was an underlying desire for political change. However, while in some programmes, this was manifested openly by CHWs through political activism, in others, under the garb of healthcare provisioning, the CHWs were empowered as change agents and challenged the status quo.

While undertaking a meta-analysis on the effectiveness of empowerment strategies, Wallerstein (2006) has looked both at the processes, which led to empowerment and also its impact on health and health disparities. She states that CHWs are a "key empowerment strategy" (2006:14). Though she notes the role of CHWs as advocates

for the community on health issues, the study has looked only at health and health services outcomes and does not include the social determinants. Similarly, in their study on individual empowerment and relationships formed between the CHWs and young mothers, Becker *et al* (2004:340) find that CHW programmes have great utility for disadvantaged communities and that “community health workers have been shown to be community change agents, empowering individuals, their community, and themselves”.

In his article titled ‘Health systems governance for health equity: Critical reflections’, Labonte (2010) lists the roles of the health system in action on social determinants as educator/watchdog, resource broker, community developer, partnership developer, and advocate/catalyst. Prasad & Muraleedharan (2007:8-9) who reviewed the concepts, practice and policy concerns related to CHWs in 110 studies, conclude that a well designed and implemented programme “could have far reaching implications for the whole society beyond generating better health outcomes”, including women’s empowerment, increase in their self esteem, help CHWs to earn respect of the community and finally, reduce social inequity.

2.2.2: Factors influencing action on social determinants

The potential of the CHW is influenced, according to Werner (1977), by various intrinsic factors like literacy level, personality, cultural background, acceptability by community, and their health priorities; and external factors like notion of the role of the Village Health Worker (VHW), nature, length and appropriateness of training, level of autonomy given to the VHW, effectiveness and sensitivity of supervision. He states that the VHW will be able to contribute the most if she/he is taught a range of

skills, given space for autonomy and self-initiative, and provided supportive supervision.

Ingram *et al* (2008:417) enumerates the characteristics of CHWs associated with advocacy work, as “their belief that they can influence community decisions, self perception that they are leaders in the community, and knowledge of who to talk to in their community to make change”. They identify specific programme elements, like CHWs working as part of a NGO rather than a health care agency or health department and working with community leaders rather than health workers, leadership training for CHWs, having flexibility of work hours and autonomy in work, which promote work of CHWs on advocacy (Ingram *et al*, 2008). They say that there is a dearth of research on this aspect and recommend that more research should be undertaken to explore and document the potential of CHWs as an advocate for the community and in impacting systems change and health outcomes (Ingram *et al*, 2008).

Many scholars have recognized the role of the nature and mode of CHW selection and accountability, in facilitating action on social determinants. For example, the first critical element in selection of a CHW is for the CHW to be from the community she/he serves (Bender & Pitkin, 1987; Lehmann & Sanders, 2007, Werner, 1977). The mode of selection would also determine the point of accountability for the CHWs. Therefore Sanders (1990) opines that as accountability of the CHW has to be to the community, especially the poor and not to the health system, the selection of the CHW has to be community-led. However, according to Bender & Pitkin (1987), accountability of the CHW depends on who pays her/his remuneration. In their study on CHW programmes in South Africa, Van Ginneken *et al* (2010) found that in cases where CHWs reported to health staff, they were seen as constituting the lowest rung

of the health system and were unable to play an effective role in linking the community to health services.

Further, in terms of criteria for selection, Krishnamurthy & Zaidi (2005) state that CHW programmes with both with literate and illiterate or semi-literate CHWs have had a successful impact. According to them, any rigidity in criteria for selection, like level of literacy, and age actually ignores the community's reflective process while deliberating on the selection. Considerations like age, family responsibilities, interest in community work, or whether the woman has time to do this work, are "subtly woven into community thought processes as they choose their CHW" (Krishnamurthy & Zaidi, 2005:11). Schultz *et al* (2002) found that the ideal CHWs were selected through the 'reputational method', that is, identification of individuals whom people already trusted, respected and went to in times of need, or self-identification by individuals who were interested to do this work.

Most scholars have emphasised the importance of both training and on-the job support to the CHWs as catalysts for action on social determinants (Bender &Pitkin, 1987; Schultz *et al*, 2002; Krishnamurthy & Zaidi, 2005). For example, training as the most important determinant of the CHWs effectiveness has been emphasized by Krishnamurthy & Zaidi (2005:11) who note that "it is within the training component that the quality of the CHW's work, her credibility, her interest, her communication skills and most importantly, her confidence gets established". They recommend that the training should include classroom and field based training, with a mix of trainers from medical and non-medical background and with standard modules and textbooks to reduce transmission loss.

Ingram *et al* (2008:418) found that mentoring of CHWs with older and more experienced CHWs was useful along with leadership training on “local politics and governance structure, advocacy, and community organizing”. They suggest that these strategies should be included even in formal CHW courses in order to “validate the activities that many of these natural leaders are already engaging in when they enter a certificate program” (Ingram *et al*, 2008:423).

Various writers have commented on training medium and strategies. Farquhar *et al* (2005) argue that use of popular media like socio dramas. while training CHWs can be useful to identify the social determinants of health and also build their capacities and knowledge in local politics, governance, advocacy and community organization. Van Ginneken *et al* (2010) found that elements like informative and non-threatening supervision and on-going training, use of culturally sensitive messages, and use of key (national/international) CHW training manuals helped towards the success of the programmes.

The importance of regular training, monthly meetings, and small action groups to address priorities was stated by Schultz *et al* (2002) in his study on the East Side Village Health Worker Partnership in addressing social determinants of health.

Other scholars have emphasised the importance of the contextual or environmental factors that shape a CHW programme and also the actions of CHWs. For example, Van Ginneken *et al* (2010) found that most of the CHWs engaged in political activism were from areas where political and social injustices had occurred. This made them question whether CHWs would be similarly committed to such political action in a more democratic political climate and where there are lesser threats to human rights. Labonte (2010) notes that there are experiences of CHWs working on equity,

especially during times of repression, when they need to take on the responsibility as the health system in itself may not be able to play an active role in action on social determinants.

A common finding has been regarding the criticality of the CHWs role on action on social determinants in marginalized and vulnerable communities (Farquhar *et al*, 2005; Perez & Martinez, 2008). It was found that the CHWs as participants in the research have been able to provide leadership in order to effectively address a number of health issues, including social determinants, among the marginalized communities (Farquhar *et al*, 2005).

2.2.3: Process of action on social determinants

Very few researchers have written in detail or described the process of action on social determinants by CHWs.

In the Arizona Community Health Outreach Worker Network, Ingram *et al* (2008:419) found that the CHWs mobilised the community to become "civic participants and problem solvers" and formed their groups to address the problems. Similarly, Farquhar *et al* (2005) found that the Poder es Salud/Power for Health project disseminated knowledge and built leadership skills among CHWs and other community members. The community was encouraged to come together around an issue and to influence decisions and events within the community thereby encouraging 'social networks' and 'civic engagement'.

A detailed description of the process undertaken in the work on social determinants in the programme under the study was given by Schultz *et al* (2002), which included developing priorities for intervention through dialogue with VHWs and community

steering committee members; forming groups for each priority area to develop and implement intervention strategies; working with the police and other agencies; capacity building for income generation; strengthening social networks; and eliciting active engagement from community, and multiple partners. According to them, this project was able to overcome some of the challenges, which emerge in working on social determinants of health (Schultz *et al*, 2002). Firstly, it was able to demonstrate how VHWs could facilitate the process and help develop skills of the community in prioritization of issues, negotiation and compromise; secondly, the VHWs facilitated collective action by the community on these priority areas by building skills and networks; and thirdly, they were able to successfully undertake process, impact and outcome evaluations (Schultz *et al*, 2002),

In conclusion, it is evident from the above literature review that firstly, there are very few studies focusing on the role of the CHWs in addressing social determinants. Secondly, though some scholars have tried to study and address various components of the CHW's work on social determinants, there are few studies looking at the whole aspect comprehensively. Finally, very few studies have articulated the lessons or recommendations for scaling up action on social determinants in CHW programmes.

2.3: The Mitanin Programme and action on social determinants

Along with articulations by various social scientists and public health practitioners and researchers about the role of CHWs in addressing social determinants it is imperative to understand whether this too has been articulated in the Mitanin Programme, which is under study . In order to do this, the Operational Guidelines and other documents describing the conceptual and the implementation issues of the

Mitanin Programme were studied, along with published commentaries by various persons involved or interested in the programme and NRHM guidelines.

As mentioned earlier, the Mitanin programme is a Community Health Worker programme, which was initiated by the Government of Chhattisgarh in 2002. The word Mitanin literally means ‘lifelong friend’ in Chhattisgarhi language. There are nearly 60,000 Mitanins, all women, covering almost all the rural hamlets of the State (SHRC, 2010). Though it is a government programme, with funds flowing and implementation being done through the health department, it is facilitated by the State Health Resource Centre (SHRC), which is an independent organisation.

The stated objectives of the Mitanin Programme are as follows (SHRC, 2010):

• To provide health education

• To mobilise communities for prevention of infections

• To provide primary curative services at the habitation level for common ailments

• To link communities with formal healthcare services

• To empower women and other socially excluded sections

• To promote grassroots health planning by bringing health on agenda of Panchayats

In 2005, all the Mitanins were recognized as ASHAs (Accredited Social Health Activists) under the countrywide National Rural Health Mission (NRHM).

A foundational document published by the State Health Resource Center in 2003, outlining the concepts and principles of the Mitanin programme, helps to understand

the historical context of the programme and the perspective with which it was started (SHRC, 2003a). It shows that the programme was formulated within the framework of comprehensive primary health care (CHPC) and aimed to address health inequity through action both on the health system and social determinants (SHRC, 2003a).

Sundararaman (SHRC, 2003a), one of the main architects of the programme writes, “persons who are selected as community health workers must be sensitive and have empathy with the poorest and the most marginalized, if not be someone drawn from their own ranks. Such a person must be owned by the community as acting on its behalf- not at the behest of the government, much less a philanthrophic institution or funding agency. These principles flow from a perception of the health worker as part of a social process for empowerment - for social and economic justice.” He writes that there is need for strengthening the civil society networks around the Mitanins in order to expand their scope of work to cover food security, education, water and natural resource management (SHRC, 2003a).

The Government shared this perspective. The Health Secretary of Chhattisgarh at that time, Dr. Alok Shukla (SHRC, 2003a:8), sets the tone for such a vision for programme. He writes; “in this system, treatment of diseases has got precedence over prevention of diseases, and programmes of improvement of Public Health. We must remember that all our policies should be made keeping communities in focus, as empowerment of people is our ultimate goal”. He further adds; “we are a firm believer in the Empowerment concept of people’s participation and are committed to ensure this in the field of Public Health. Government of Chhattisgarh has launched the “Mitanin” scheme for this purpose” (SHRC, 2003a: 12). Biraj Patnaik (SHRC, 2003a) shares the perspectives that emerged during the initial consultations between

Government, funding agencies, health activists, and NGOs with respect to the design and vision of the Mitanin Programme. He writes that there was a consensus that, “to achieve the vision of ‘Health for All’ there was need to make a transition from existing health services to community-based health services” (SHRC, 2003a: 37). The community-based health services model would be based on structural understanding of poverty and gender issues, put emphasis on the socio-economic and cultural determinants of health along with preventive and promotive healthcare, and be controlled, managed and governed by the community (SHRC, 2003a). In order to make this happen, the Mitanin programme would have to be supplemented by wider policy reforms.

As part of the Programme design, the Mitanins were not to be paid any honorarium by the government and it was hoped that community-based mechanisms would emerge for compensating the Mitanin’s work monetarily (SHRC, 2003a). The Operational Guidelines enumerates the reasons for this decision to not pay the Mitanins: (1) “Firstly the Mitanin should not have to face any loss of livelihood on account of her participation. Only that much work must be given as can be done without loss of livelihood” (SHRC, 2003a; 24); (2) “The greater concern and reason for not paying compensation is that while the amounts considered are too meagre to amount to a livelihood, the payment would make the entire burden of work solely her task and the community would fall back (SHRC, 2003a; 24); and (3) “not paying her safeguards selection process from pressures that would otherwise be inevitable and most damaging” (SHRC, 2003a; 25). However, since the introduction of the National Rural Health Mission in 2005, the Mitanins are entitled to various task-based incentives (NRHM, 2005b).

The support structure for the Mitanin Programme has been well defined since the beginning of the programme as it is seen as critical in ensuring continued participation and engagement of the Mitanins even in the absence of monetary compensation (SHRC, 2003a). The Operational Guidelines envisage that within the village, support will come from women's groups, the *panchayat* (village councils) and from regular meetings between Mitanins (SHRC, 2003a). The support from outside the village would be mainly from the Mitanin Trainers, the others being the cluster health worker, village nutrition worker, and medical officer. One Mitanin Trainer would assist around 20 Mitanins. The role of the Mitanin Trainers (or *Prashikshak*, literally meaning Trainer) was seen as most critical in the success of the programme. It is imperative to note that they have been called 'Leaders of the Mitanin Movement' (SHRC, 2003a). The guidelines describe their role very succintly- "*Prasikshak* is a Trainer of Mitanins. But over and above this they are expected to emerge as the local leaders of the Mitanin Programme. They need to be specially trained and motivated to play this role" (SHRC, 2003a: 76). The Mitanin Trainers in turn are supported by two or three full time Block Coordinators.

The foundational document written at the start of the programme describes in detail the training methodology and the issues and skills to be taught (SHRC, 2003a). It outlines how training on curative care occurs nearly a year after the Mitanin is selected in order to prevent the Mitanin from getting trapped in to the 'prevailing culture' of considering health as just a disease requiring medicines and injections, rather than focusing on preventive and promotive health and community organisation (SHRC, 2003a). The training of the Mitanins is of two kinds- institutional training and field based practical training in which "the training is designed to bring in positive attitudes in the "Mitanin" about the power of people, empowerment of women, the

strength of community work etc" (SHRC, 2003a: 14). This perspective is followed through in the modules of the programme. The first module enumerates the determinants of good and ill health, taking into account the social, economic and political determinants, including issues of inequity. Slogans like 'health is our right', 'health for all', and 'our health in our hands' have been part of the training curriculum and social mobilisation efforts. The module on women's health starts by discussing issues of gender inequity through the life cycle and also has a chapter on violence against women. Specific issues of food security and work entitlements were discussed as part of the eighth Module. All the modules cover aspects of health as a right, sensitisation against victim blaming, need for the community to plan for itself, and issues of inequity (SHRC, 2003a).

Recent documents/articles on the Mitanins have shown that along with improvements in health and mortality indicators, and improved access to health services especially of women and children, Mitanins have indeed also been involved in action on social determinants and health inequity (Batiwalla, 2007; Sundararaman, 2007; Sanders, 2008; Dhote, 2009; Rajshekhar, 2010; Dasgupta, 2012).

2.4: Evidence on outcomes of the Mitanin Programme

Annual survey data by the Registrar General of India showed that the rural infant mortality rate (IMR) in Chhattisgarh decreased from 95 per 1000 in 2000 to 52 per 1000 in 2010 (SRS, 2002; 2011). The significance of this may be seen in the fact that rural IMR for the whole country during this period fell from 74 in 2000 to 51 in 2010 SRS, 2002; 2011). Therefore in terms of percentage points, the reduction in rural IMR in Chhattisgarh (43 points) was nearly double of India's (23 points).

Rajshekhar (2010) documented improvements in anemia and breastfeeding practices between 1998/9 and 2005/6 (Table 3).

Table 3: Improvements in anemia and breastfeeding practises between 1998/99 and 2005/06

Indicator	India 2005-06 (%)	Chhattisgarh 2005-06 (%)	Chhattisgarh 1998-99 (%)
Children under three breastfed within 1 hour of birth	23.4	24.5	13.9
Children between 6-35 months who are anaemic	78.9	80.9	87.7
Married women between 15 and 49 years who are anaemic	56.2	57.6	68.7

Source: National Family Health Survey 2 (1998-99) and NFHS 3 (2005-06)

While these gains in mortality and health status in Chhattisgarh State could be due to a number of factors, the Mitanin Programme has been the most significant health intervention in the period. This is highlighted in a series of case studies, articles and local evaluations, and has been given extensive coverage in the popular media (Nandi, 2005; Batiwalla, 2007; Sundararaman, 2007; Sanders, 2008; Dhote, 2009; Rajshekhar, 2010; Dasgupta, 2012).

Batiwala (2007) states in her article that Mitanins have "improved child survival rates in the state, furthered local women's participation in the community, and helped

ensure people's right to food”. She further describes how Mitanins, along with healthcare work worked on right to food, feeding practices of neonates and put a stop to starving women after delivery.

Evidence of the Mitanin’s work leading to improved health status; drug availability at the hamlet level; and decrease in mortality was documented by Dasgupta (2012). She also writes about Mitanins being involved in improving mid day meals in schools and in stopping deforestation.

In his article in *Lancet*, Sundararaman (2007: 2059) writes, “community participation and the empowerment of women cause change. The many Mitanins who have since entered elected office in local governance bodies, and the successful Mitanin-led community actions against deforestation, for securing of tribal livelihoods, for early childhood-care facilities, or against alcoholism and corruption are testimonies to the so-called unintended positive outcomes”. He reiterates; “the role of these volunteers evolved over time into a set of activities that focused on child survival and essential care of newborn babies, and into another set of rights-based activities that enabled access to basic public services as fundamental entitlements to be secured through women’s empowerment and community action”.

Additional evidence on Mitanin’s action on social determinants may also be found in the Mitann Programme monitoring data and in a recently completed Mitanin Evaluation. The Mitanin Programme Monitoring Information System (MIS) captures instances of action on food security and domestic violence. Analysis of Mitanin Programme monitoring data of seven months (January 2011 to July 2011) showed that on an average, per month Mitanins helped in around 1860 cases of domestic violence while 7% of Mitanins intervened in food security issues (SHRC, 2011).

An Evaluation of the Mitanin Programme undertaken in 2010-11 explored the perception of community women with regards to the Mitanin's involvement in local issues (EUSPP, 2011). While 80% of the respondents said that Mitanins work on healthcare, 39% said that Mitanins addressed issues related to children's feeding programme (ICDS), Mid Day Meals in schools and MNREGS (employment guarantee programme). Thirty percent of the respondents said that Mitanins intervened in the *gram sabhas* (unit of local governance) while 19% said Mitanins deal with any issue that concerns the community (EUSPP, 2011).

CHAPTER 3. RESEARCH DESIGN AND METHODOLOGY

3.1: Study Aim

To describe the role of CHWs, in the Mitanin Programme, in addressing social determinants of health in Chhattisgarh State of India

3.2: Objectives

- To map the scope of the CHW's work in Chhattisgarh and describe the processes by which they address social determinants of health, specifically nutrition and violence against women.
- To describe some of the successful efforts of CHWs in Chhattisgarh in addressing these social determinants of health.
- To explore the challenges faced and the facilitating factors in the CHW's action in addressing these social determinants of health.

3.3: Methodology

3.3.1: Study Design

An exploratory comparative case study design using qualitative research methods was adopted for the study.

3.3.2: Justification for selection of the study design and research methods

A case study, as defined by Yin (2009: 16) is "an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident". Green & Thorogood (2004: 37) quote Yin's argument that "the case study is the research

design of choice when a "how" or "why" question is being asked about a contemporary set of events over which the investigator has little control". Keen & Packwood (1995) state, "case study evaluations are valuable where broad, complex questions have to be addressed in complex circumstances". The issues being explored in the study are complex, and deals with the broader definition of health, processes, relationships, components of empowerment and participation, and social experiences, all within a context.

The qualitative research method was suited for this case study as "qualitative methods enable public health researchers to apply theoretical understandings to otherwise rhetorical concepts such as participation and empowerment", which is not possible in experimental research (Baum, 1995:464). Similarly, Green & Britten (1998) argue that qualitative research is able to answer a number of questions related to processes, and interactions which quantitative research cannot. The literature review of studies exploring the role of CHWs in working on social determinants showed that there is little description of the process of undertaking such action. Most studies, though qualitative, are reviews of literature or commentaries on CHWs (Bender & Pitkin, 1987; Wallerstein, 2006; Labonte, 2010). The few qualitative studies using case study methods have been able to cover the aspects in a more comprehensive manner (Ingram *et al*, 2008; van Ginneken *et al*, 2010).

3.3.3: Study Population

The study population consists of all cases of successful action by a CHW (Mitanin) or team of CHWs (Mitanins) on the social determinants of nutrition and violence against women, since the beginning of the programme in 2002.

3.3.4: Definition of a Case and Case Selection

In the study, the definition of a case is 'successful action by a CHW (Mitanin) or team of CHWs (Mitanins) on nutrition or violence against women, one which has impacted a positive change in the particular social determinant of health in the context of the village/cluster of villages for which the CHW/s are responsible'.

The sample consists of two case studies, one each on nutrition and violence against women. The reasons for choosing these two themes are manifold: 1) Malnutrition is a very serious issue in India which is otherwise experiencing very high economic growth (Joe *et al*, 2008). The malnutrition figures in India are in fact higher than that of sub-Saharan Africa. 2) Furthermore, the issue of malnutrition has been linked to the low status awarded to women in Indian society (Ramalingaswami *et al* (1996). 3) The two issues reflect both the structural (gender) and intermediary (nutrition) determinants of health inequity (CSDH, 2008). 4) Finally, existing literature on the Mitanin programme shows that these are the recurring themes in the action by the Mitanins on social determinants of health (Batiwalla, 2007; Schaay & Sanders, 2008; Sanders, 2008; Sundararaman, 2007).

The sampling of the two particular cases was undertaken "to identify the cases that will provide a full and sophisticated understanding of all aspects of the phenomenon" (Rice & Ezzy, 1999:42). The two case studies provided evidence on two levels of action by CHWs vis-a-vis social determinants. The first level of action is within the community where, for example, gender bias, and perceptions on domestic violence have to be challenged in addition to nutritional counseling by the CHWs. The second level of action is that of demanding entitlements from the state, for example, demanding improvements in government run nutrition programmes, or demanding that the police or doctor attend to victims of domestic violence.

As per the requirements of a multiple-case study design, the sampling followed the 'replication logic', which means that "each case must be carefully selected so that it either (a) predicts similar results (a literal replication) or (b) predicts contrasting results but for anticipatable reasons (a theoretical replication)" (Yin, 2009: 54). Two cases having 'literal replication' were selected. The cases in the study were selected purposefully through discussions with the field and management staff of the Mitanin Programme, and other stakeholders as ones with "exemplary outcomes in relation to the research question" (Yin, 2009:59). The cases selected were two blocks: Durgkondal for action on nutrition and Manendragarh for action on violence against women. Blocks were selected as cases as they are the basic unit of Mitanin programme implementation.

Sampling of respondents within each case was done through snowball sampling in which the "initial respondent, or group of respondents, is asked to suggest other people who may be willing to participate in the research" (Rice & Ezzy, 1999:45). During the initial visit to these blocks, interviews with key informants (Mitanin Trainers/Block Coordinators) led to identification of Mitanins and villages where successful work on the social determinants had taken place. Thereafter, the researcher visited these villages and undertook data collection through Group and Individual Interviews with the community and the Mitanins. In both cases, ongoing training (in the case of Durgkondal) and meeting (in the case of Manendragarh) were also utilized as sites for group interviews. These group interviews helped also to identify individual cases of successful action for further insights. For example, in Manendragarh, after a Mitanin group interview in the village, two Mitanins were identified and separately interviewed. In Durgkondal, the group interview of Mitanins

during training helped in identifying one of the villages where later the researcher went for data collection.

The district level programme staff and state level official were subsequently interviewed.

3.3.5: Data Collection

Data collection was undertaken through In-depth Individual Interviews and Group Interviews with CHWs, community members and programme staff that participated with the CHWs, and also benefitted, in their action on social determinants. Review of articles and reports about the Mitanin programme was also undertaken.

The researcher herself undertook data collection. However, members of the Mitanin Programme supported greatly in the field level logistics. All interviews were done in Hindi language and in the specific dialect of the study location. The interviews were recorded, transcribed and translated.

Both the group and individual interviews were guided by a broad conceptual framework, covering the role of Mitanins' action on social determinants, impact on social determinants, challenging and facilitating factors. Though in both cases, action had taken place on both the determinants (nutrition and violence against women) to an extent, only information on the determinant under study and in which the Block showed 'exemplary outcome' (Yin, 2009), was elicited in depth. Familiarity with the subject matter helped the researcher to undertake more number of interviews than initially planned for.

Seventeen in-depth interviews and ten group interviews (total 27) were conducted (Table 4).

Table 4: Number of Individual and Group Interviews undertaken in both case studies

Data collection	Manendragarh	Durgkondal	Total
Individual Interviews of Mitanins	6	6	12
Individual Interviews of Mitanin Trainers	1	1	2
Individual Interviews of District Coordinators	1	1	2
Individual Interviews of SHRC State level Official			1
Group interviews with Mitanins	1	2	3
Group interviews with community women	2	1	3
Group interviews with Mitanin Trainers	1	2	3
Group interviews with Block Coordinators		1	1
Total Individual Interviews	8	8	17
Total Group interviews	4	6	10
Total	12	14	27

Data collection was done in phases and simultaneously with analysis so that the researcher could go back to a few of the participants or go to new participants in order to clarify or verify certain issues or validate the emerging findings and explanatory framework (see Analysis, Section 3.4). After analyzing the data, discussions were held with district and state level programme staff of the Mitanin programme regarding the conceptual framework.

3.3.5.1: In depth Interview

For the individual interviews, the study used a semi-structured interview, which is a respondent interview where the interviewer is in control of the interview (Robson, 1993). An interview guide was used to carry this out (Appendix 4). In-depth Individual interviews were conducted with CHWs, and Mitanin programme staff (state, district, and block level).

The Interviews of the Mitanins were held in their respective villages and with the Mitanin programme staff, at the Block or in the village being visited. The interviews were usually held in the interviewee's house. Attempts were made to sit in places where there was peace and quiet so that the interview would not be disturbed and recording would be clear.

3.3.5.2: Group Interview

Group interviews were also conducted using an interview guide (Appendix 5). The various types of "natural groups" (Coreil, 1995) from which information was collected, were of programme staff like Block-coordinators and Mitanin Trainers, Mitanins and community members who have acted along with the Mitanin on social determinants. The group interviews with people from the community consisted of

only women. Initially, the researcher had not planned for Group interviews with Mitanins, however, after a few individual interviews, researcher found that though rich data regarding the process of action on social determinants emerged from the interviews, a better understanding of the catalysts for action and programmatic inputs and environments factors could emerge from group interviews of the Mitanins.

The group interviews were held in the village and in the training/meeting hall.

3.3.5.3: Review of documents

Documentary sources describing Mitanin's action on social determinants and the outcomes were studied. These mostly included reports and documents of the Mitanin Programme, articles and media reports, and statistics. Though information regarding the specific social determinants was not available, the documents were used to gauge the type of action and outcomes of the programme, specifically on various social determinants.

3.4: Analysis

"An important step in all of these replication procedures is the development of a rich, theoretical framework" which can be used as a framework for generalisation and which may be modified as per the findings (Yin, 2009:56). Therefore, in order to facilitate analysis in this multi-case study design, a conceptual framework was developed at the start of the research. The data collection and analysis were done with relation to this conceptual framework, which ultimately evolved into an explanatory framework (See Figure 4).

The analysis in the multi-case study design is two-fold (Yin, 2009). First, both cases were analysed and written up separately. Then the two cases together were analysed

in order to draw cross case conclusions. As with the multiple case-study design, analytical generalization was attempted through replication logic, which is "if two or more cases are shown to support the same theory, replication may be claimed" (Yin, 2009: 38-39).

The analysis of the data was done following the three processes of description, classification and connection (Gifford, undated). Once the initial recordings were transcribed, the researcher went through the transcripts and identified themes from them. These themes were related to objectives of the study and conceptual framework. Data from each subsequent individual interview and group interview was then categorized into those themes. This was a dynamic process as new themes emerged and older themes were refined, while going through the subsequent transcripts. This whole process was done separately for both cases. At this point of time, the conceptual framework was revisited and modified accordingly.

For cross case learnings, the researcher placed categorized data from each case and pasted it physically on a bigger chart paper. There was a separate chart paper for each theme. Any point from either case, which did not correspond to one in the other case, was kept separately and included only in the individual case but not in the cross-case learnings. The themes broadly represented components of the conceptual framework. The conceptual framework was then again modified as per the cross-case learnings.

After that, once again, the researcher went through the transcripts to check that no points have been missed either in the individual cases or in the cross-learnings and also that all points have emerged from the transcripts themselves. Special care was taken to check the influence of the researcher's experience and perspectives.

3.5: Trustworthiness

Yin (2009) suggests the use of tests of construct validity, internal validity, external validity, and reliability as measures of ensuring rigour and trustworthiness in case-study research.

For credibility and validity of data, triangulation of methods and of data source was undertaken (Gifford, 1996). This was done through the use of two different data collection methods from different groups of people about the same action, that is, from the Mitanin, the community members of her village who were involved in the action and Mitanin programme staff, in addition to review of articles/documents.

The methods of data collection and the strategies of data analysis have been made explicit (Gifford, 1996). Changes in the study protocol were discussed with the supervisor and documented herewith, made explicit and justified and form an 'audit trail'. Notes were taken along with audio recording of the individual interviews. This data will be preserved and available for future analysis.

A case study database was developed during the process of data collection and is available for scrutiny. Rigour in the research was attempted through reflexivity. Malterud (2001) writes that reflexivity can be achieved through identifying preconceptions and perspectives of the researcher, study beforehand the beliefs of the researcher regarding the context and what is to be investigated, motivation and qualifications for undertaking this research. As an insider to the programme, and especially since she had worked in one of the sites (Manendragarh), there was the danger of researcher's experience influencing the analysis. The researcher was conscious of this and therefore stayed vigilant both in data collection and analysis of the Manendragarh study. As a significant amount of 'independent' literature is

available on the Mitanin's work on social determinants in Manendragarh, not selecting that Block would have been detrimental to the study. The researcher was able to use the relationship with the participants to an advantage, especially because the issue under study was a highly personal and sensitive issue. Additionally, having worked with Mitanins since the programme started put the researcher in a unique position to undertake this study, however, the researcher was always conscious of this and took care that this did not compromise the trustworthiness of the study.

During data analysis, pattern matching and explanation building were attempted towards internal validity. This has been described in the section on data analysis (section 3.4). The researcher checked and rechecked to see that her views/perspectives didn't influence the findings that emerged from data. As analysis was concurrent with data collection, any decisions that were regarding change in protocol were documented.

The limitations of the study have been discussed below. This includes acknowledgement of limitations of generalizability but also make the areas of transferability clear (Gifford, 1996). As Malterud (2001) suggests, the context and background information of the cases have been detailed in the individual case studies, along with environmental factors, in order to determine extent and areas of transferability possible. The use of replication logic in the multiple case studies will address issues of external validity (Yin, 2009).

The methodology and findings of the study were presented at different points of time to stakeholders and feedback elicited from them. For example, interviews of district and state programme staff were held after rest of the data has been collected. Some of the findings were presented to them and their responses elicited. The conceptual

framework was also shared with SHRC State official and feedback was taken from him regarding the framework. This was then incorporated into the analysis. This has helped in maintaining rigour in the study and construct validity.

3.6: Limitations

Being qualitative in nature, this study is not be able to give any estimates on the proportion of CHWs addressing social determinants, or the extent to which the two cases represent the norm or instances of positive deviance in the Mitanin Programme. Rather the study gives insights into why something happened in a particular context, why some participated, and what were the processes involved (Baum, 1995).

‘Statistical generalisation’ is thus not possible in this study, which means that the results will not be generalisable to the study population, and instead ‘analytical generalisation’, which means, to “expand and generalise theories”, has been achieved (Yin, 2009: 13).

A large number of cases may have lent more dimensions to the research topic at hand; in particular, selection of a case with adverse outcomes might have strengthened the development of the conceptual framework.

As discussed above, the researcher could be considered an insider to the Mitanin Programme, and despite awareness of this, may have created a bias in favour of the programme. If resources had permitted, an evaluation that was complemented with an outsider’s perspective strengthens the validity of findings. To some extent the independent perspective of the supervisor assisted in providing a critical viewpoint on the data and analysis.

Even though interviews of health service providers were initially planned for, they could not be held due to lack of time. This perspective is thus missing from the mini-thesis. However, as the purpose was to understand internal programme mechanisms and processes, this would not have added appreciably to the analysis.

3.7: Ethical Considerations

Ethical Clearance was obtained from the UWC's Senate Research Committee. Subsequently, permission was obtained to undertake the study from the State Health Resource Center which is the body coordinating the Mitanin Programme in Chhattisgarh.

Appointments were made with participants at times and places that minimized interruptions to the participant's daily routine, which may have had financial implications. The block-level Mitanin programme staff facilitated this. For data collection during an ongoing training or meeting, the researcher waited for the day's proceedings to end and then organised the group interviews. Special care was taken so as not to interrupt any economic activity the participants were engaged in. In Durgkondal, the Block Coordinators traveled with the researcher to the villages on few of the trips. The researcher provided them with refreshments/lunch and ensured, through dialogue with the Mitanin programme management, that they would be given wages for that day as with other working days.

In data collection the first step was in taking informed consent from the participants. A Participant Information Sheet (Appendix 1) and Informed consent form for both the individual and the group interviews were prepared and translated into Hindi (Appendices 2 & 3). The form for the group interview included a confidentiality-binding clause. The forms were read out, as many of the participants were non-

literate. Agreement was reached on certain details such as naming of village of the report. This was discussed with the participants and included in the consent form itself. Thereafter verbal consent was taken.

One concern was that the participants would see the researcher as an authority figure, and they may not be in a position to refuse the interview, despite her giving them the opportunity. In order to neutralise this, the researcher remained vigilant throughout the data collection process to pick up verbal and non-verbal cues as to whether the participant/s were willing to share a particular information or not and not resort to any form of coercion or pressurize them to answer. The researcher also attempted not to give her views (verbal or non-verbal) on the issue being discussed. However, the researcher found that all the participants were eager to speak about their experience and many a time during the Group Interview everyone would speak excitedly, all at once which she had to then facilitate. After every interview or group discussion there was a debriefing session to allow participants to ask questions and give any further views about the data collection. Only in a Mitanin Group Interview in Durgkondal did a Mitanin ask the researcher about the rumour they had heard about Mitanins receiving government salary, to which she responded. The Information sheet also contained the researcher's phone number however, none of the participants other than the Block Coordinators, contacted her at any point of the study.

Anonimity of the respondents has been maintained during the research and the report writing and the records have been retained safely with the researcher.

Overall there was a commitment to sensitivity, respect, courteousness and tactfulness towards the participants. The results of the study will be shared with the State Health Resource Center and through them, to the participants. In the event of publication of

results of the study in form of an article or case study, due acknowledgement will be given to all persons (participants and others) involved in this research.

4. RESULTS

4.1: Socio-economic, political and programme context

The study was conducted in Durgkondal and Manendragarh blocks. Durgkondal is one of the Blocks of Kanker district, which is situated 140 kilometres south of the state capital with nearly half of its area under forests (Figure 1). Manendragarh Block is in Koriya district, which is situated at the northwest corner of Chhattisgarh, and is at a distance of 340 kilometres from the state capital, Raipur. Koriya is one of the most densely forested areas of Chhattisgarh with a forest cover of more than 59%. Both blocks have a high tribal population (Table 5).

Table 5: Geographical, and demographic characteristics of the two Blocks

	Durkgondal Block	Manendragarh Block	References
District	Kanker	Koriya	
Distance from State Capital	140 kms	340 kms	http://kanker.nic.in http://korea.gov.in
Total area (district)	5285 sq. kms	5978 sq. kms	http://kanker.nic.in http://korea.gov.in
Forest coverage (district)	48%	62%	FSI (2011)
Rural Population	55321	75255	Calculated from Census, 2001
Tribal Population (Rural)	77%	63%	Calculated from Census, 2001

Tribal groups	Gond, Halba	Gonds, Cherwas, Pandos, Agaria, Oraon and Baigas	http://kanker.nic.in http://korea.gov.in
Adult sex ratio (rural)	1007	955	Calculated from Census, 2001
Rural Literacy Rate (district)	69%	66%	Census, 2011
Female literacy (district, rural)	59 %	55%	Census, 2011
Male literacy (district)	80%	77%	Census, 2011

Both Durgkondal and Manendragarh blocks are identified as 'Scheduled Areas'. Scheduled Areas are areas with sizable proportion of tribal population, which are identified in Schedule V of the Indian Constitution. The Panchayat (Extension to Scheduled Areas) Act gives special powers to the village councils (*panchayats*) and it's General Body (*gram sabha*) in Scheduled Areas (PHRN, 2010). The *Sarpanch* is the head of the village council and is elected after every five years, along with the village council members. In addition to these councils, the National Rural Health Mission has introduced village level health committees called the Village Health Sanitation and Nutrition Committees. These committees are provided funds annually and are expected to undertake village health planning on prevailing health issues and its determinants. The convener of the committee is the Mitanin. *Panchayat* members (or Panch), village level workers of all government departments, women leaders and members of youth group are members of this committee, which is expected to formulate village action plans and work on them (NRHM Chhattisgarh, 2011).

Being remote and tribal areas, the health system in both blocks are fraught with problems like difficulty of access, lack of health human resources, and poor health infrastructure resulting in poor quality of health services (PHRN, 2010).

The Mitanin Programme structure in all blocks is similar and shown diagrammatically in Figure 3:

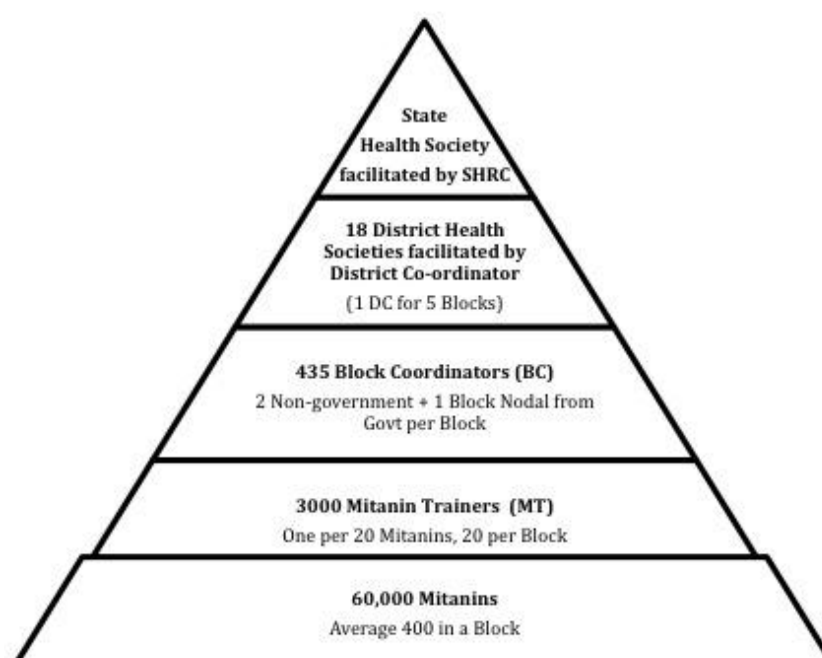

Figure 3: Mitanin Programme Structure

While funds flow through the government institutions, all the people in the support structure are contractual employees, recruited from civil society.

Mitanin training is conducted through a training cascade. The state-level team trains the District Coordinators, who in turn conduct trainings of Block Coordinators and Mitanin Trainers. The Block Coordinators and Mitanin Trainers organise and conduct trainings of Mitanins. Initially, Mitanin training was held at the cluster level, amongst a group of villages, however, in recent times the training is held in batches at the

block level for easy logistics and quality assurance (SHRC State official Interview). The Training is mostly residential in nature. The various rounds of Mitanin training are given in Appendix-6.

The following case studies present the findings from the respective Blocks under study. Both case study narratives follow a similar structure. First a background of the Mitanin Programme in the Block is presented, including the selection process in the Blocks. Subsequently, the situation of the determinant prior to the Mitanins' working on it is described followed by a presentation of various factors which acted as catalysts to Mitanins' action on social determinants. This includes factors integral to the programme and environmental factors. The emerging role of the Mitanin is then discussed. Following this, the process of taking action on the social determinant is described along with the changes that have come about therewith. Finally the challenges, both existing ones and the ones that the Mitanins had to face in action on social determinants, are presented.

4.2: Case study on Mitanin's action on nutrition in Durgkondal Block of Kanker District

The Mitanin Programme in Durgkondal was initiated in 2003 during the second phase of the programme when the programme was expanded to all Blocks of Chhattisgarh. The first step was to select the Block Coordinators, then known as District Resource Persons (DRPs), which was the responsibility of the block level health department officials of the Block. The Block Coordinators and the ANM (Auxiliary Nurse and Midwife stationed per 3000 population) in turn selected women Mobilisers who later

became Mitanin Trainers. The Mobilisers, after receiving training on community mobilisation and Mitanin selection, organised meetings in the villages and facilitated selection of the Mitanins. The village councils were also consulted in this matter. In Durgkondal literacy seems to have been a major consideration for Mitanins selection as majority of the Mitanins who were interviewed during the study had studied at least up to primary school level.

"Block Medical Officer selected the two DRPs (now called Block Coordinators). Both were women. The Block coordinators and ANM chose the Mitanin Trainers. The Mitanin Trainers did meetings in villages, sat in village council meetings (panchayat) and got villagers to choose Mitanins. In most villages, Mitanins were first selected through village meetings and then got approved by village council head (sarpanch)" (Mitanin Trainer Group Interview, Diyagaon).

"I was selected in village meeting by village leaders. They said I was literate and can talk well" (Mitanin Interview, Diyagaon).

"The Mitanin Trainer came to the village and explained about the [Mitanin] programme and asked me whether I wanted to do this work. Then she organised a meeting for selection and I was chosen" (Mitanin Interview, Dangra).

"Panchayat decided to send me for Mitanin Trainer training as I am disabled and have studied till 12th" (Mitanin Trainer Interview, Dangra).

It was found that in Durgkondal a large number of existing Mitanin Trainers and even the Block Coordinators had been Mitanins before. The two previous Block Coordinators had been promoted as District Co-ordinators.

In order to strengthen the Mitanin's work on nutrition issues, SHRC introduced a new person at the block level called the Nutrition Fellow who is from the Mitanin Programme and focuses on nutrition issues in the block. Nutrition fellows have now become a quintessential part of the programme and have been placed in 70 out of the 147 blocks in the state (SHRC State official Interview). The Mitanins in Durgkondal have also used Village Health Sanitation and Nutrition Committees as a vehicle for action on food.

In order to understand the Mitanin's work on nutrition, it is important to understand the various ongoing government programmes on food and nutrition. The programmes explored in the study are enumerated as follows[2]:

Mid Day Meal Scheme (MDM): Under this scheme a hot cooked meal, consisting of rice, lentils, vegetables, desert and condiments, is provided to all government school children till class 8. It also includes a morning snack. Currently, women's self help groups (SHGs) are engaged in providing this meal. This has improved the provisioning however certain systemic problems exist like delay in receiving funds and grain by the SHGs, resulting in compromised quality of meal.

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[2] Information regarding scheme and its functioning taken from Mitanin module "*Poshan, Cehat aur Samajik Suraksha*" (Nutrition, health and social security) (SHRC, 2006)

Integrated Child Development Services (ICDS): This includes a feeding programme for all children under six years of age and pregnant and lactating women. There are ICDS centres or *anganwadis* in every village, and at times more than one in a village. Daily an ICDS worker and helper provide pre-school informal education to children aged three to six years, a hot cooked meal, and morning snack. Once a week, children under three and pregnant and lactating women receive dry rations for the whole week. Health check up and nutritional counselling are also provided. In this programme too, currently women's self help groups manage the food provisioning, including decentralised production of the dry supplementary nutrition.

Public Distribution System (PDS)- Under this scheme, subsidised grain is provided to nearly 76% of the population in the state through community run shops.

Pension scheme: Under this scheme, monthly pensions are provided to poor widows, single women, aged, and people with disabilities.

Mahatma Gandhi National Rural Employment Guarantee Scheme (MNREGS): This scheme was introduced through an Act of the same name. It guarantees a minimum of 100 days of employment for every rural family. It stipulates measures of transparency, accountability and timely wage payment and services to be made available at the worksite for the benefit of the workers.

A recent intervention by the health department has been the setting up of Nutritional Rehabilitation Centres (NRCs) in some of the hospitals for management and treatment of severely malnourished children. Under this programme, a child identified as having

severe acute malnourishment (SAM) is kept in the facility for 15 days under supervision and provided food and treatment.

4.2.1: Situation of nutrition before Mitanins started working on it

In Durgkondal block, the prevailing issues in nutrition included non-functioning of food programmes and existing traditional practices related to denial of food to women and children. This, along with low community awareness regarding these issues and gender discrimination, increased the vulnerability of the community, especially of women and children.

The various programmes like Mid Day Meal, ICDS, and PDS were not functioning as per the norms. The government workers, that is, the teachers in the schools and the ICDS workers in the ICDS centres were managing the food provisioning. Corruption by government workers meant that food destined for children, women and the poor did not reach them.

"In the feeding programme, earlier they were not providing proper food and gave food of bad quality"(Mitanin Group Interview, Durgkondal).

"Earlier the salesman [of shop distributing subsidised grain] would come and go as he liked and opened the shop whenever he liked" (Mitanin Group Interview, Durgkondal).

“In our village mid day meal was not cooked properly….either lentils or vegetables were given, never both. No chips or pickle [was given]. Less amount of food [was] given to children” (Mitanin Group Interview, Durgkondal).

“In our village [in ICDS centre] only lentils were given and that too in small quantities” (Community Group Interview, Pawarkhera).

People did not have complete information regarding entitlements of all the food programmes, as the government workers would intentionally not share this information with them. The villagers knew vaguely what the beneficiaries were to receive but were not aware of the details. Moreover, the community was not aware of the utility of the feeding programmes. This, along with a badly functioning programme would deter the people from participating in these programmes. The food being distributed was also not to the liking of the local community and therefore children would not be sent to the centres. As a result of all this, people, especially children were not accessing their rights and were excluded from entitlements.

“We also did not know how much children are supposed to get” (Mitanin Group Interview, Durgkondal).

“We did not know about our rights and hence were not concerned about them” (Mitanin Group Interview, Durgkondal).

“Earlier children had not even seen the ICDS centre and women never went to get dry food rations” (Mitanin Group Interview, Durgkondal).

Within the community there existed certain practices, which would deny nutrition to women and children. The community was not aware of the significance of feeding colostrum to the newly born child and therefore would throw it away. A number of food practices were related to pregnancy. Food was not given to women for three to four days after she delivered. They were made to drink only herbal tea, which was not adequate for their own sustenance and their child's. As a result, women would become very weak and there would not be adequate breast milk for the newborn. Many a time this led to the death of the mother or the infant. There were also a number of nutritious food items like green vegetables, leafy vegetables, eggs, and fish, which a lactating woman was not allowed to eat. In addition to this, for nearly two to three months after delivery, they were given meals in small quantities. This exacerbated the existing problems of anaemia and malnutrition both in the mother and the child.

"They did not give food for 2-3 days after delivery. They would not give lactating women rice, or green vegetables but only rice water and that too once a day. They would give [her] very little food for 2-3 months. So mother would get very weak" (Mitanin Group Interview, Durgkondal).

With regards to participation in community processes, women were not allowed to attend village meetings and if they came, it would just be to listen. They would not be allowed to talk. The Mitanins too were restricted to their own households before they joined the programme and considered themselves as *"aam mahila"* (like any other woman). However once they joined the programme, they became mobile and active in

the village. They would go outside the village for trainings. Villagers, mainly men would make fun of them and chide them. The village leaders and 'village elite' would question the legitimacy of the Mitanin's work and would confront her when she went for village meetings.

"Bada aaj kal Mitanin banis to khub bade bade batatey hain chotey chotey mun. Bada durgkondal jaatey hain training lene....pata nahi kya training lene jaatey hain...bade bade Mitanin baney hain" (now that they have become Mitanins, small people have started saying big things. How [proudly] she goes for training to Durgkondal….we don't know what training she gets there…..Mitanin thinks herself to be great now) (Mitanin Group Interview, Durgkondal).

"In the beginning they said, you are Mitanin so why have you come here [to the meeting]? What is your role? Show us something [proof]"(Mitanin Trainer Group Interview, Durgkondal).

4.2.2: The catalysts for Mitanins to start working on issues of nutrition

"[We work on nutrition] Because we were trained for this and told in training to do this. We learnt it from the book" (Mitanin Group Interview, Durgkondal).

The Mitanins in Durgkondal started working on nutrition issues after the first round of training in 2003-04, which had a module on child health. This module is called "*Hamarey Bachchey, Unki Cehat*" (Our Children and their Health) (SHRC, 2003b). The first chapter of this third Mitanin module provides an understanding of health inequity with respect to children and its socio, economic and cultural determinants.

The second chapter deals with malnutrition, with focus on the vicious cycle of poverty, ill health and malnutrition. It goes on to explain crucial messages for nutrition along with their rationale. The rest of the chapter teaches the Mitanin how to determine nutrition status of children and undertake nutrition counseling in a sensitive and non-threatening manner. The rest of the chapters include understanding on various diseases like diarrhoea, cough and cold (SHRC, 2003b).

"We learnt in the training that woman will get weak, have to feed immediately. Only then will adequate milk come out for the baby and mother will be healthy. We learn a lot about technical things. We can tell all this to family and other villagers. We get information during the training"(Block Coordinator Group Interview, Durgkondal).

However, the Mitanins started working on improving the functioning of government food programmes mainly after the eight round training. This module was called "*Poshan, Cehat aur Samajik Suraksha*" (Nutrition, health and social security) (SHRC, 2006). It is in this training that they received information about all the social security programmes and also learnt how to work on them. The first few chapters provide an understanding on what is malnutrition, how to measure malnutrition, relationship between malnutrition, hunger and starvation and community based strategies to prevent malnutrition. The subsequent chapters deal with the various government food schemes, like the PDS (subsidised grain), Mid Day Meal (for school children), ICDS (pre school feeding programme), pensions, employment guarantee scheme, and programmes for the most vulnerable groups like the aged, migrants, landless, and single women (SHRC, 2006).

"It is written in the 8th round book that Mitanins should know of government programmes and she should monitor these and act"(Mitanin Trainer Group Interview, Durgkondal).

"*We Mitanins have got training where the book said what should be available in the village, what are our entitlements. Then we started seeing whether we get those things" (Mitanin Group Interview, Dangra).*

Supportive supervision and handholding by the Mitanin Trainers and the Block Coordinators have aided the Mitanins in their work. Regular review and planning meetings are organised by the Trainers, whereby Mitanins gather and discuss their experiences, problems, and plan for the future. These regular meetings of the Mitanins have been useful in all action by the Mitanins.

"We [Mitanins] attend cluster meeting where there is revision of previous lessons. We bring information and report and share it in the meeting. We report on all work we are doing" (Mitanin Group Interview, Durgkondal)

"We [Master Trainers] have three meetings a month where we understand things and then we transfer the information to Mitanins at cluster meeting. Then they transfer those things in hamlet meeting."(Mitanin Trainer Group Interview, Durgkondal).

"We organised Cluster meetings of 20 Mitanins each and this helped to unite Mitanins. We had 10 clusters and we would make it a point to reach. Then larger cluster meetings of Mitanins and villagers started. Mitanin cluster meetings were very useful. We would do review of training/book, do discussions on many issues, they

would learn from each other, and we would together also write applications/complaints." (Block Coordinator Group Interview, Durgkondal).

In addition to the trainings and meetings, the Mitanin Trainers have been providing regular field level support. In Durgkondal there seems to be a strong bond between the Mitanin and the Mitanin Trainer. The Mitanin Trainer was the one who facilitated selection of the Mitanin and then has been training her and providing on the job support. If there is any issue, which the Mitanin is not able to resolve, she takes help from the Trainer and the Block Coordinator. The Mitanins spoke of the Mitanin Trainer as a mentor, as the person from whom they have learnt everything they know.

"We made them understand about giving the mother food. Mitanin Trainers and Block Coordinators also helped to explain [this] to the villagers." (Mitanin Group Interview, Durgkondal).

"If we are not able to resolve something we call Mitanin Trainer/Block Coordinator" (Mitanin Group Interview, Durgkondal).

Having received training on nutrition and food issues, Mitanins felt that they now had the legitimacy to work on these issues. It also became clear to them that working on nutrition and right to food was part of working on health.

"When we got training and we were told to go and see these things and improve the situation, we then got to know that we have the right to intervene in these matters too" (Mitanin Group Interview, Durgkondal).

"If [there is] no food then how will person be healthy?" (Mitanin Group Interview, Durgkondal).

Having people believing in them also motivated the Mitanins to continue working on these issues. In Durgkondal, the Mitanins have been able to gain the trust of the community by proving themselves in providing care for women and children. They take women to the facilities for delivery and provide timely care and referral for the children, including neonates. They have also fought against out of pocket expenditure during delivery in the government hospital as a result of which free treatment is now provided in the hospital.

"Their first child had died as they were late in getting to hospital. In the second pregnancy I prepared her for going to hospital early and so the child survived" (Mitanin Group Interview, Durgkondal).

"The villagers think that we have made the mother and child secure." (Mitanin Group Interview, Durgkondal).

"Mitanin didi rahis to hamar ladika ke jaan bachis" (Our son survived because of Mitanin sister) (Mitanin Group Interview, Durgkondal).

The Mitanins are volunteers and don't get any regular remuneration. They started receiving certain incentives after the start of the ASHA programme under the National Rural Health Mission in 2005. However, these are of small amounts and are far between (SHRC State official Interview). This did not seem to deter most of them

as they expressed that they feel good that they are able to meet other women, people recognise them, and they learn many new things. Family members are also happy that they are recognised for their good work. Only one Mitanin who was interviewed said that they should get money for all kinds of work that they do and not only for the ones listed in the guidelines.

The District Coordinator said that information about other women doing collective action on various issues was also a motivation for the Mitanins to take similar actions. Having meetings specifically for Right To Food issues by a Nutrition fellow was very helpful. He added that the Fellow has been able to do advocacy with the department and has also fought with them about their (government's) hiding the actual malnutrition status of children.

Traditionally there existed a system of conflict resolution, though women did not get to participate. However, the tribal nature of the area and the tradition of village meetings and certain collective action might have facilitated and supported the Mitanin's attempts (SHRC State official Interview).

"Sarpanch, ward panch helped us to deal with violence against women even before we became Mitanins"(Mitanin Interview 1, Karramar)

"There was some awareness before and people would try [to improve things] but only after the Mitanin programme started, they could take larger action" (District coordinator interview, Kanker).

Many of the Mitanins said that they always had a desire to do some work outside their household. It is pertinent that in the selection process, many such women were chosen as Mitanins or became part of the support structure either by choice or by chance.

"I used to go to gram sabha (village council general body) to listen to what was happening. I was self-motivated to go to meetings. Family would have some problem but then I used to go for small periods of time to the meetings"(Mitanin Group Interview, Dangra).

"I was always the fighting type. One day I saw a man beating his wife. I went and gave him a couple of slaps"- (Block Coordinator Group Interview, Durgkondal).

"I always wanted to do something but then I got married. My mother in law put my name for Mitanin without telling me. But I am very glad that she did"(Block Coordinator Group Interview, Durgkondal).

4.2.3: The Mitanin's role

The above elements have catalysed the Mitanins' action, including on nutrition and right to food and defined a role for the Mitanins.

The Mitanin is engaged in healthcare work, like mobilising for immunisation of children, ensuring safe delivery of women, looking after pregnant and lactating women, taking care of neonates, forcing health workers to be regular in their duty, and demanding health services.

They have also been working to ensure proper functioning of food schemes; ensure proper and timely wages are paid in the government employment programme (MNREGS); demand safe drinking water in village; undertake counseling on nutrition and take action to reduce violence against women and ban alcohol.

As a result of the work she has done, the villagers seem to respect her and listen to whatever she says. They consider her as a special person ("*khaas aadmi*"). People feel that the Mitanin says things that are correct, useful and good. They admire the fact that even though she does not get anything, she is always ready to help, even at night. Mitanins too feel good about this.

"Sahi baat bolti hai" (she says right things) (Mitanin Trainer Group Interview, Diyagaon).

"They [community] think she goes to so many trainings and meetings so she must be learning things. They think she goes leaving her house and house-work so she must be learning good things"(Mitanin Group Interview, Pawarkhera).

As a result of a lot of her successful healthcare work, people now believe in her. People come to her for help, as they know that she will definitely do something for them. Her work has led to a lot of improvements in the community. The community believes that she has saved children's lives, they can see visible change in weights of children, there has been some improvement and so they now believe in her. Men especially think that they can accomplish things that they themselves as men haven't managed to do.

"Earlier women used to hide their problems. Now they share everything with the Mitanins. They think she will definitely do something for me. [Now] they believe in her" (Mitanin Trainer Interview, Dangra).

"They were scared earlier to go to hospital. We said we will go with you. They experience it and come back and tell others"(Mitanin Group Interview, Pawarkhera).

The District Coordinator is of the opinion that that the Mitanins are known to take action especially on the behalf of the poor and about their rights. The Mitanins also believe that they have the right or the legitimacy to speak out about entitlements.

"Haq hai to usey jaakey bolengey" (It is our right therefore we will speak out and take action) (Mitanin Group Interview, Durgkondal).

4.2.4: Process of taking action on nutrition

The Mitanins in Durgkondal started their action on nutrition by first building awareness and understanding about the issue in the community. The Mitanins disseminated information regarding nutrition and food schemes to the community, especially to women, during hamlet meetings, village health committee meetings and home visits. They explained the utility of the feeding programmes and persuaded the families to access them.

"Earlier people [were] not sending children to ICDS center. I explained its importance to nutrition and health and motivated [them] to send. They have started

sending. Parents also go periodically to the center for monitoring" (Mitanin Group Interview, Durgkondal).

"With regards to the ICDS programme, people first said why should we send them for a meal when we can feed them at home. We make them understand. We say your children can play there. Gives you time for doing your work. They are not there to disturb you" (Mitanin Group Interview, Pawarkhera).

Other than the community, the Mitanins also share information with the service providers and members of the village councils. Though the service providers are aware of what they are to provide, they often fake ignorance in order to avoid providing as per norms. Dissemination of this information creates a pressure on them to provide entitlements as per the norms. In this, the Mitanins make use of the modules and resource materials given to them to show that the information is legitimate.

"We took the book to gram sabha (village council general body meeting) and showed it to the sarpanch (village council head)" (Mitanin Group Interview, Pawarkhera).

"If they don't listen [to us], we show them the book so they listen to us" (Mitanin Group Interview, Durgkondal).

"We told in the village about menu to be given to the children and showed the book so they had to believe us" (Mitanin Group Interview, Durgkondal).

There seems to be a lot of solidarity between various cadres in the Mitanin Programme in the Block. The Block Coordinators mentioned that it was very important for them to first build solidarity among the Mitanins. After that the Mitanins, Master Trainers and Block Coordinators together built unity amongst women. They did this by mobilising women through organising regular meetings in the village. These meetings are conducted at the convenience of the villagers especially women so that most of the women are able to attend. Subsequently they also started organising larger meetings of women at the cluster level. Block level meetings of Mitanins and women are organised annually for a show of solidarity and to put forward any unmet demands in a unified manner.

"We do meetings of women and explain the rights. We have been doing meetings since 3rd round (women's health). Block coordinators and Master Trainers taught us and then when we went to the village we shared it with others. We first explained in village meeting, and cluster meeting and then we went together to talk to the service providers and make then understand. We do meetings once a month in the village"(Mitanin Group Interview, Durgkondal).

"We would do meetings again and again tell them why are you shouting in village? Go to the bigger meeting and tell the problem"(Mitanin Group Interview, Durgkondal).

In the action on nutrition, the Mitanins mobilised women to put pressure on service providers to provide the entitlements as per norms. They persuaded the villagers to monitor the services being provided and intervene in case of any default.

"We discussed in women's meeting. We [Mitanins] have got training where the book said what should be available in the village, what are our entitlements. Then we started seeing whether we get those things. We shared this information with other women of the village and discussed how things are not as they should be. We built consensus that we should work on MDM. We told our Mitanin Trainer who helped us. Now lentils and vegetables both are being cooked. Ever since we made VHSNC, we discuss there and things have started improving"(Mitanin Group Interview, Dangra).

"If only we [Mitanins] went, it would not do. So we told other village women and 3-4 of us then went to the pre-school centre to talk to the worker. We pressurised her to give food to the children as per norms. She started giving properly" "(Mitanin Group Interview, Durgkondal).

"Women used to say, why should we go anywhere? What work do we have? Don't we have work at home? Don't you have work that you are galavanting around? We said that we understand that everyone has housework, but this is also about everyone's rights- everyone's children go to feeding center so we all need to act. Slowly slowly they understood. Not all at once, but one by one" "(Mitanin Group Interview, Durgkondal).

"Earlier they used to only cook lentils in the ICDS centre. We [women] started monitoring and told them to cook better. Mitanin was also a part of the group cooking the meal so she also understood and started giving as per menu"(Mitanin Interview, Dangra).

"Our ICDS worker used to take all the stuff which would come for kids, to her house. The villagers caught her and reported against her. They discontinued her service and now a new worker is being selected" (Mitanin Group Interview, Durgkondal).

"Earlier they would just cook anything and feed them. I went with village women and made her understand. She then started giving properly" (Mitanin Group Interview, Durgkondal).

If the situation did not improve through negotiations and threats at the village level, the Mitanins would facilitate writing complaints or applications to be submitted at higher levels.

"When we discussed these issues, the government officials did not listen to us. Then we gave written complaints about delay in wages to village council and Block and it improved" (Mitanin Group Interview, Dangra).

The Mitanins elicit help from the support structure (Mitanin Trainers, Block Coordinators, District Coordinators) when they are not able to resolve an issue.

"Food was not being given properly in our village ICDS centre. We [women] went again and again and told them to improve. When she did not listen, we took Block Coordinator to help and pressurise her. Now she's giving properly" (Mitanin Group Interview, Durgkondal).

Mitanins have made use of the local governance structures in their work on nutrition and forced them to intervene in various issues. In many villages, Mitanins also stood for elections and have been elected to the village councils.

"We did action on Mid Day Meal around two years back. Earlier children were not getting vegetables. We did many meetings and wrote in VHSNC meeting register. Then we gave [the complaint] in written to the village council (panchayat) which sent it to senior officials after which it improved" (Mitanin Interview, Diyagaon).

Though many of the workers and service providers resent this intervention by the Mitanins, they are unable to argue with the moral arguments the Mitanins use to pacify them. The Mitanins say that they are not acting against the worker or complaining against her/him, rather they are merely trying to ensure that the children of the village receive their correct entitlements.

"Workers could not fight us as we simply told them this was the norm. Also we had proof of what was to be given. They made some excuses, but they had to agree and improved the services. Now it is running properly" (Mitanin Group Interview, Durgkondal).

"The Mitanin would say I am not complaining against you, I am simply trying to improve the health of the children in my village"(Block Coordinator Group Interview, Durgkondal).

In the attempt to change traditional practices related to denial of food to women and children, the Mitanins would counsel the whole family. She would go to a woman house while she is still pregnant and advise the family what to do after delivery. Many a time if the family were not willing to feed the woman after delivery, the Mitanin would herself feed the woman who has just delivered.

"I explained to them that if they didn't give food she will get weak and not be able to do much work, and will fall ill. We used to tell the mother in law. She used to say that our Mother in law never gave us so why should we give? I would again and again try to make them understand. We would also advise for [colostrum] that it is beneficial for the child. We made them understand. Our Master Trainers (Mitanin Trainers) and Block Coordinators also helped to explain things to villagers" (Mitanin Group Interview, Durgkondal).

"We ensure the woman gets to eat food immediately after delivery even if I have to cook it. In case the family is telling lies, we sometimes cook food ourselves and feed in front of us, both food to mother and [colostrum] to the child" (Mitanin Group Interview, Durgkondal).

A lot of the action on nutrition has been spontaneous and responsive to the emerging issues. Mitanins on their own undertake various actions on urgent problems. The District Coordinator said:

"Many a time women start some struggles and we get to know afterwards. We don't need to tell them what to do every time. They themselves start their own struggles as per the problems in their hamlets" (District Coordinator Interview, Durgkondal).

The process of taking action by the Mitanins and their support structure on any issue is quite relentless. They don't easily give up and pursue an issue till it got resolved. This has ensured their success in most interventions they take up.

"We take action on things. We don't let issues remain. We keep trying till we succeed"(Mitanin Trainer Group Interview, Diyagaon).

"We would go again and again to make them understand. Now there are a lot of improvements" (Mitanin Group Interview, Durgkondal).

"The pre-school feeding programme was not working properly and the worker was not regular. All women got together and wrote to village council. The worker did not listen to the council head (sarpanch) and so nothing improved. Then they gave written complaint to the higher officials of the programme and to elected people's representatives at the block and district. The women put a lot of pressure and as a result, the worker's salary was stopped for some time. Now the centre is working fine.

Now the worker comes daily, many children come and proper food is cooked. We feel good about this" (Mitanin Group Interview, Durgkondal).

4.2.5: Changes that have come about in nutrition

The changes that have come about in the Block with regards to nutrition are manifold. There has been an improvement in functioning of food related schemes and as a result, more people are now utilising these schemes. The community has started monitoring of food and nutrition schemes. Mitanins are able to take up issues at all levels, from village to district level. Along with this, certain policy changes like food provision by women SHGs, change in menu to include local foods, and opening up of ICDS centres even in remote hamlets have led to an increase in access of the people to these entitlements (SHRC State official Interview).

As a result of the Mitanin's efforts, most women are given food after delivering. As a consequence of action on rights by the Mitanins, women have been empowered and now women don't get scared to speak out. They also participate actively in village councils The Mitanins themselves feel empowered. They go for trainings, and meetings for which they have to travel outside their house and village.

"Now even a lone woman speaks out. Now they don't get scared. They have been empowered" (Mitanin Group Interview, Dangra).

"Now even when men beat women speak out"(Block Coordinator Group Interview, Durgkondal).

"Earlier women would go to meetings only to listen. Now they go to speak out"(District Coordinator Interview, Durgkondal).

"Earlier we never had any information or knowledge. Ever since we joined Mitanin, we have got information about many things" (Mitanin Group Interview, Durgkondal).

Earlier people, especially women, would hide their problems. Now they come to the Mitanin to share their problems and ask for advice. The Mitanins are now given recognition by all for doing good work. They are called to public meetings and functions to give lectures. Earlier the village leaders would create problems for them but now they too have started respecting the Mitanins as they realise that Mitanin is doing good work in spite of not being paid anything. The villagers now call them "*hamari Mitanin*" (our Mitanin). In many villages, the Mitanins were given awards on the 'Day of the Mitanin' that was celebrated all over the State on 23rd November 2011.

4.2.6: Challenges faced

Challenges still exist for the Mitanins. Even today many people, especially from the more powerful groups or the 'village elite' harass the Mitanin. They belittle her work and say, *"you think you are great and know everything"*. The Mitanins themselves feel that a lot more work is needed on gender issues. As one Mitanin said, *"we have to work more for equal rights for women"*. In many villages issues got resolved easily while in some villages the Mitanins and other women have to endure a long struggle. At times this leads to frustration and de-motivation. There is hidden resentment among the government workers against Mitanins and many a time this manifests

itself. In some of the villages of the block, the Mitanins face problems in organising meetings due to the presence of extremist groups.

Though the Mitanins are pleased that the number of women is growing in meetings, however, they feel that more and more responsibilities have come on women. They are concerned that the number of men coming for the meetings is decreasing and they are not taking any responsibility in community action.

The District Coordinator said that it is essential to ensure that the Mitanins get adequate support, including monetary incentives for the tasks she is undertaking. A Mitanin also brought up this issue and she demanded money for attending meetings. However, the District Coordinator was of the opinion that in the guise of demanding rights for the Mitanins, some people are bringing negativity into the programme for their own vested interests and are promoting unionisation of the Mitanins. He said that in neighbouring districts union leaders of health staff were very active in mobilizing Mitanins and their support structure to demand regular employment from the government and this had affected the programme adversely.

However, despite the challenges, the Mitanin's work on nutrition is getting stronger. In the last three months, the State Health Resource Centre has started a campaign against malnutrition. The Mitanins have identified severely malnourished children and brought them to health facilities. As a result of the pressure by the Mitanins of Durgkondal and the neighbouring block Bhanupratappur, the government was forced to start a Nutrition Rehabilitation Centre at Bhanupratapur. The Mitanins of

Durgkondal have also started participating in larger campaigns on food and nutrition issues at the state level.

The District Coordinator sums up the contribution of the programme: *"Mitanin programme has achieved 'change of heart' in people".*

4.3: Case study on Mitanin's action on violence against women in Manendragarh Block of Koriya District

The Mitanin Programme started in Manendragarh in 2002 during the first phase of the programme. As in case of Durgkondal, Mobilisers (women) were first selected by the health department staff and trained in spreading awareness about the programme and facilitating selection of the Mitanins by the community. Alongside, folk media was used for social mobilisation around the programme. The Mobilisers, who were subsequently incorporated in the Programme as Mitanin Trainers, conducted meetings in the villages and facilitated selection of Mitanins. The village councils were also consulted in selection. An enquiry into the selection process shows that mobility, amount of household responsibilities, availability of time for such work and not literacy (unlike Durgkondal), were the main considerations made by the community while selecting Mitanins in Manendragarh.

"Mankuwar had gone to the village and did meeting for selection of Mitanin. They chose me as they said she is alone, she can be mobile." (Mitanin Interview, Kariabehera; estranged from husband and non-literate).

"Rambati came and said I have to make Mitanin. I was wondering how will I do it? [She] said we will give training and then give medicines. I said I am illiterate, how will I give medicines without knowing. She said we will first teach you and then will give medicines. Every month there will be training. I said I will ask village leaders. She said that the village council had suggested my name. They had said that I was free so I could do this work. Others will not be able to do this. I said its fine, I will do it, but if anything goes wrong, it's your responsibility"(Mitanin Interview 1, Rokda; widow).

As in Durgkondal, a large number of Mitanin Trainers and Block Coordinators in the block had been Mitanins previously and had climbed up in the structure. Therefore, they don't consider themselves as separate from the Mitanins and a lot of their work and their articulation are done as Mitanins.

In Manendragarh block, the Mitanin Programme is complemented by an intervention called the Koriya Initiative that was started around the same time by one of the collaborators of the Mitanin Programme. This initiative aimed to mobilise tribal communities to fight for their rights (SHRC State official Interview).

4.3.1: Situation of violence against women

Violence against women was entrenched in the prevailing situation of gender discrimination and low status awarded to women in the area. Discrimination against women and girls in the villages was reflected in, among other things, unequal wages for women, forcing girls to drop out of school and getting them married at a very young age.

Women would not be allowed to participate in any decision-making processes in the village or community. They would not be called to any village or community meetings. In case some of them went, they would not be allowed to sit either in front of the men or speak. As seen above, during the initial days of the Programme most of the women who were selected as Mitanins had not been part of the village meetings for their own selection.

“If we went to meetings we would be asked, why have you come here? There is no role for women in these meetings” (Community Group Interview, Rokda.)

Women were subjected to various forms of violence, including physical violence, sexual/physical abuse, withholding food, and verbal abuse. Though domestic violence was the predominant form, women narrated instances of sexual harassment of girls by neighbours and acquaintances, and physical violence by members of own or other’s family due to conflict between brothers or between families. Women expressed that they were not aware of their rights and therefore did not think that they could speak up regarding violence- *“We did not have rights and so we would not tell anyone about violence against us” (Community Group Interview Rokda).* On the other hand, men would be free to act in any way they want and they would not be scared to inflict violence, as expressed by Mitanins below,

“Jaise man chahey waise karte the” (they [Men] could do whatever they wanted) (Mitanin Interview 1, Rokda).

"Pehele phokat ka raaj tha" (earlier it was free for all [for men])(Mitanin Interview, Gundru).

Therefore, women felt extremely helpless in case of violence, especially domestic violence. They couldn't go to anyone for help as no one would listen to her part of the story or take her side. Even if the woman told her family or neighbours about her problem, they would instead find fault with her. A participant said that women would think, *"If no one is ready to help me then why should I go to anyone?"(Community Group Interview Rokda).* Even the village councils would not intervene on the woman's behalf and instead find fault with her, therefore, women felt that there was no one who would intervene on their behalf and give them justice. As one Mitanin Trainer said,*"Koi sunai nahi hota tha" (no one would listen [give us justice]) (Mitanin Trainer Interview, Kachod).*

The police too were not responsive. The participants spoke of how they all (including Mitanins) were scared of the police. In their experience, the police would harass and humiliate the women rather than helping them. Like one participant said, *"If the woman had notes [money] then she would maybe go to the police otherwise she stayed quiet"(Community Group Interview, Rokda).*

Hence, the woman subjected to violence would either keep suffering and enduring the violence silently or would run off to her parent's house. Often, if the woman resisted the violence, the man would also kick her out of the house. In many of these cases then the woman would flee to her parent's house and stay there till her husband brought her back and then the cycle of violence would resume.

In the beginning of the Mitanin Programme, as the Mitanins started becoming active on various issues, villagers, mainly men would initially chide them for moving around the village and organising meetings of women. They would say, *"Bada Mitanin baney ho" (so you think you're great because you have become a Mitanin); "Duniya bhar ka meeting jutatey ho" (what all rubbish meeting you call women for) (Mitanin Trainer Group Interview, Manendragarh).* Women themselves would initially hesitate to come to the Mitanins with their problems. This mirrors the situation in the Durgkondal case study.

It was in this environment that the Mitanins started working on violence against women.

4.3.2: Catalysts for Mitanin's action on violence against women

As in the case of the case study on nutrition, the Mitanin's work on violence against women in Manendragarh started after they received training on it in the third round of training, which was on women's health. When asked where they learnt to intervene in violence against women, one of the Mitanins simply said: *"we learnt from the book" (Mitanin Interview 2, Rokda).* The module (number four) on women's health was called "*Mitanin Tor Mor Goth: Mahila Swasthya ke Vibhinna Ayaam*" (Mitanin, about you and me: various aspects of women's health) (SHRC, 2003c). It was in this training, which took place in 2004-05 that the Mitanins were first taught about gender issues and the rights of women. They learnt how violence against women was about denial of women's rights. They learnt how to build awareness around it in the village and also how to intervene in such cases. Use of popular training methodologies like

role-plays and group discussions helped in relating the subject matter to their own experiences and in cross learning.

A review of the chapters of this fourth module reveals that women's health was articulated in a very comprehensive manner, which included gender and how it affects women's health, violence against women and women's empowerment. This was in addition to chapters on adolescents, anaemia, pregnancy, government health services for women and special health problems faced by women (SHRC, 2003c).

The Chapter on women and violence mainly focuses on domestic violence though it does talk of all types of violence inflicted against women in society. The chapter starts with a story, which participants are encouraged to act out in a role-play. The realities behind many myths regarding violence are exposed in the subsequent portion. Various other important aspects are discussed, like understanding why women usually don't want to leave their husbands, in what situations are women more vulnerable to violence, and the cycle of violence. It highlights that violence against women is a social problem and not a domestic issue. It ends by talking about how to reduce discrimination between girls and boys. It explains in great detail the role of the Mitanins in reducing violence against women in the village, including encouraging the victim to speak about the violence, counseling her, teaching her self defence, eliciting help from the village councils, other villagers, women's organisation and taking the legal recourse. It also gives practical tips, like a list of items the woman needs to take with her if she decides to leave the house and the various institutions she can go to for help (SHRC, 2003c).

Having undergone training on this issue, the Mitanins now understood work on health as encompassing working on violence against women. They explained how violence affects the health of the women,

"If every day we are getting beaten, [then] how will we stay healthy? Mentally also don't stay well.....don't eat well. If someone is physically ill, then we can give medicine, but in this case we have to act and fight against it and only then can one get well"(Mitanin Trainer Group Interview, Manendragarh).

"This is part of working on health. Because of violence there is mental tension, eat less food, and become weak" (Mitanin Interview, Kariabehera).

Receiving training and information on violence against women and understanding the issue and ways to work on it, gave the Mitanins the confidence and legitimacy to work on it as was in the case of action on nutrition. They linked it to the broader issue of women's rights and therefore their work on violence against women necessarily included interventions on emphasising rights of women.

"We were not aware of it [women's rights]. Even if we knew we would never ask for it. We now understand about intervening in violence so does that not mean that we now understand our rights?"(Community Group Interview, Rokda).

Subsequent to the training, the Mitanin Trainers and Block Coordinators also started discussing and reviewing work on gender issues and violence against women in their regular meetings with the Mitanins. In the meetings Mitanins would discuss specific

cases and elicit support from other Mitanins, Trainers and Block Coordinators. They felt that this was a forum for sharing their experiences and for learning from each other.

Being a woman herself and being part of the community and social strata they work in, Mitanins themselves had also experienced violence. As a result, they empathised with the victims and felt great solidarity with them. Having had similar experiences of violence, they felt compelled to act against it.

"We are also women so we can't bear to see women suffering. If this happens to one woman, it can happen to everyone" (Mitanin Group Interview, Badkabehera).

"Because we too have experienced such things ourselves and we understand the pain"(Mitanin Interview, Machidand).

Therefore, acting on violence and gender issues have also led to certain positive changes in the lives of the Mitanins themselves, including being subjected less to violence. As one of the Mitanins said,

"Earlier I would also be beaten but since I became a Mitanin, he does not hit me. I think I will NEVER [emphasis by participant] leave this work"(Mitanin Interview 2, Rokda).

According to the District Coordinator, both Mitanins and other women of the village welcomed the work on violence against women, as it addressed problems that were

very real and painful to them. She said, *"This [programme] talked of their pain and gave them the chance to do something about their problems"(District Co-ordinator, Koriya).*

The action on violence against women by Mitanins has been part of their overall work in mobilising and organising women. The Mitanins have organised the women and encouraged them to take action on various fronts, like improving immunisation, improving functioning of food schemes, and stopping deforestation (Nandi, 2005). This has helped the Mitanins in gaining acceptance in the village, and also helped them in their work on violence against women. They formed an organisation, the *Adivasi Adhikar Samiti* (Tribal Rights Organisation), with other tribal women of the area.

"Sangathan banane se dar bhaggis" (our fear went away when we got united) (Mitanin Trainer Group Interview, Manendragarh).

Working on all these issues also forced them to interact with the police and other government administrative structures. In the face of adversity the women faced the police and the erring government officers in a united manner and emerged victorious in most cases. This built their confidence. The author has documented such action in an article in 2005 (Nandi, 2005). She describes how a Mitanin Trainer (named Mankuwar) and a Mitanin (Jaimatiya) took on strong vested interests to ensure that rice from the public distribution system (PDS) reaches the poor. Despite death threats by the people running the shop and pressure from their own families to stop this work, Mankuwar and Jaimatiya took on the District Vice-President of the ruling party who

ran the PDS shop and had not given rice to a single poor family in three years. This led to police action against the shop keeper and poor families started getting their rations for the first time in three years. The Mitanin Trainer has since then been elected as the *Sarpanch* (village council head) and the Mitanin is a *panchayat* (village council) member.

These successes strengthened their organisation and made them more confident of dealing with all issues.

"We have understood our power and strength and so have the villagers" (Community Group Interview, Badkabehera).

Certain external factors may have facilitated the action by the Mitanins on violence against women in Manendragarh block. The Koriya Initiative, as mentioned above worked closely with the Mitanins and would have strengthened the Mitanin's work in Manendragarh. This initiative also exposed the Mitanins to larger campaigns on gender rights and right to food and health leading and therefore building their capacities to work on these issues (SHRC State official Interview).

The District Coordinator was of the opinion that Manendragarh, being an area with high percentage of tribal and poor communities; the problem of violence would be more visible. This along with more openness in tribal societies may have made it easier to work on issues of violence against women.

4.3.3: The Mitanin's role

As presented in the Durgkondal case study, here too one finds that various inputs catalysed action by the Mitanins on many issues, including on violence against women, thereby defining her role.

"Mitanins fight for everything, help in everything"(Mitanin Trainer Group Interview, Manendragarh).

The Mitanins have intervened in healthcare services, malnutrition, right to food, community monitoring of health and nutrition services, forest rights, deforestation, women's rights, banning alcohol and against gender discrimination and child marriage. Their work on healthcare includes ensuring immunisation, promoting delivery in facilities, giving primary treatment, referring patients to hospitals, and taking care of pregnant women and neonates in addition to ensuring regularity of doctors and reducing malpractices by health workers.

The community considers the Mitanin knowledgeable and admires that she is able to talk to people and make them understand issues. They say that the Mitanin speaks out fearlessly and is a protector of rights. As one group said, the Mitanin is able to do and say things, which others are scared to do or say.

"Jo koi nahi bol pata, Mitanin bol deti hain" (she is able to say [speak out] things which no one is able to say) (Community Group Interview, Rokda).

The Mitanins too consider themselves as being upholders of rights and promoters of justice. They are motivated for their own sake and for the sake of the community and future, to ensure that justice is done and things change.

"If we don't intervene men will keep on abusing (women)"(Mitanin Trainer Interview, Kachod)

"Women also are human beings, not animals, then why should she bear with it?"(Mitanin Interview, Kariabehera).

"We also want this [violence] to stop so that our children don't have to face it in the future"(Mitanin Trainer Group Interview, Manendragarh).

Women said that they come to the Mitanin for help as she listens to them and takes action accordingly on their behalf. The other leaders of the village don't have a good record of taking action on these issues, especially with sensitivity towards women. The Mitanin are always available to help and they help everyone. They are able to call meetings, negotiate and ensure that justice is done.

"Hamesha saath deti hai Mitanin" ([community thinks] Mitanin always helps us) (Mitanin Trainer Group Interview, Manendragarh).

"The Mitanins organise meetings, cluster meetings, motivate leaders of the organization, discuss on all issues, prioritise most critical issues and motivate the

community to take action like writing applications/complaints" (District Coordinator Interview, Koriya).

Women trust Mitanins and believe that they can help them successfully because they have won many other struggles. The Mitanin is seen as someone who speaks of and intervenes in real problems being faced by the community. The District Co-ordinator opines,

"Mitanin speaks of relevant issues; issues close to people and their problems. As she is [from] amongst them, she knows the exact problems. She speaks of real things, actual problems, so people listen to her" (District Coordinator Interview).

4.3.4: Process of taking action on violence against women

The process of taking action on violence was found to be very similar to that of nutrition action in the Durgkondal case study. However, due to the inherent nature of the issue, the action on violence seemed to demand and elicit more intensive and active participation of women.

The process of taking action on the issues of violence against women in Manendragarh started by organising and uniting women. As per the training on women's health and violence, Mitanins started organising hamlet level meetings of women. Through these meetings they would share information and discuss issues related to gender, women's health and violence against women among the community, especially women. As a result of the meetings, the women realised that

the Mitanins also work on violence against women and they started coming to the Mitanins with their problems.

“We tried to make the women understand these issues and they listened to us”(Mitanin Group Interview, Bakabehera).

“Now we have got information about this (violence against women) issue and so we ask for help”(Community Group Interview, Rokda).

The Mitanins now had to deal with this new set of issues that they had not dealt with previously. They started getting information about cases of violence by asking about it in meetings. Many a time, the woman who was subjected to violence would come to the Mitanin for help. Sometimes neighbours would come to the Mitanin about a certain case and seek her intervention. One Mitanin narrates,

“Another woman came to me for help from the village headman’s house. She came to me saying that her husband suspected her of having an affair and therefore was hitting her. I went to their house and counseled the husband. Now it’s been a year and he has not hit her. He did not hit her much, only one slap, but I saved her”(Mitanin Interview 2, Rokda).

There is much solidarity among the Mitanins and they help each other out whenever necessary. In cases where the Mitanin feels that she is not able to resolve a case on her own, she calls other Mitanins of the village or neighbouring village and also her Trainer and Block-Coordinator to help her deal with the case. Having access to

information regarding women's rights, legalities, and duty of the police and government has empowered the Mitanins and other women. The Mitanins along with other women confront the police when they try to deny certain entitlements like giving receipt of a complaint. The Mitanins have made use of the resource materials and books in order to disseminate information among the village leaders and sometimes even among the police.

"Whenever we get any paper [resource material], we make the village council head read it"(Mitanin Interview 1, Rokda).

"We would teach police the rules. The brochure we got on rules for arresting women was very useful. Even some policemen asked for it. When a woman was going to be kept overnight in the police station, the Trainer called up the station and told them to send her back as there was no female police stationed there. They then brought her back to the village" (Mitanin Trainer Group Interview, Manendragarh).

The steps taken by Mitanins in acting on cases of violence against women are mostly similar. Once the Mitanin is made aware of a case of violence against women, whether through neighbours or from the victim herself, she first attempts to deal with it within the village. She usually calls a meeting of neighbours, mainly women. The accused is brought forth in the meeting. Women leaders and village council representatives are also called for this meeting. They ask the victim to narrate the incident and also to tell them what action she wants to be taken against the accused. In case she does not want to go to the police, the group then admonishes the man and also threatens him that if ever he does this again, he will be taken to the police. He is

also made to apologise to the victim and promise that he will never again hit her. All this is documented and signatures taken of the man and people gathered. The following quotes illustrate this process:

"Women now speak out after a few beatings and come to me. Then I do meeting after gathering people in the neighbourhood. I ask them whether this is right. Hitting is not ok. What if she was your daughter? Would you not feel bad? Does she have no respect? Then people start thinking, yes if this happens to our daughters and sisters we will not like it. Everyone has equal respect" (Mitanin Interview 1, Rokda).

"I take [couple of] women with me. Why should I go alone? I tell them that if they [villagers] don't understand [what I am saying] then you all have to explain" (Mitanin Interview, Gundru).

"It is [also] our [village's/community's] responsibility. It is not only the Mitanin's work……Now when there is fighting all of us collect together and counsel them. We take some action. We would never do this before Mitanin [programme started]." (Community Group Interview, Rokda).

In some cases neighbours or Mitanins get to know of the violence as it is happening and immediately reach to stop it. The Mitanins have mobilised other village level workers like the ICDS worker, village council representatives, schoolteacher, and the Mitanin Trainer to help in this immediate intervention. Women said that earlier they were apprehensive in intervening in any such fights but now they understand that this

is not a personal or family issue but a social one and the Mitanins have been instrumental in bringing about this change in perception.

“We’d tell other women if you don’t help now, how can you expect others to help you when you are in trouble?”(Mitanin Trainer Interview, Kachod).

Often the Mitanins has to build the confidence of the victims of violence to enable them to speak out.

“Last year I met one woman crying on the road. When asked she said my husband hit me a lot. I asked her whether he was at home. She said yes and I went with her to her house. She was reluctant in taking me home, saying that he will hit her. I said “main hoon na” (I am there). I will not let him hit you. I asked the man why did you hit her. He said “she is my wife and I can do whatever I want. She likes to go everywhere, to the market etc. so I hit her”. I scolded him a lot. I threatened to take him to the police and get him beaten up. He apologised and said that I will not hit her. Since that day he has not hit his wife. He got scared of Mitanins”(Mitanin Interview 2, Rokda).

The village councils, which form the local governance structure in the area, are usually not active in dealing with cases of violence against women though it comes within their jurisdiction. Mitanins have compelled village council representatives to help them take action on the issue of violence against women. They call the members (*panch*) and the head (*sarpanch*) for the meetings and involve them in the resolution of the issue.

"I take along the village council member and other neighbours. I tell them that the village council member should take action along with the Mitanins. It is the duty of the members…......If anyone has any problems and goes to the village council head, she sends them to the Mitanin. Village council head calls me to all meetings and I also call her for [violence] cases if I'm not able to do it alone"(Mitanin Interview 1, Rokda).

"The husband hit the woman. Her father came to the Mitanin. Mitanins said lets resolve it in village council. We took her to the council head. We had a meeting and gave her the option of going to police. She went to police and the man was in jail for some time" (Mitanin Trainer Group Interview, Manendragarh).

As above, there are cases in which the victim wants to file a police complaint. In most of these cases the Mitanins too, along with other women of the village, go to the police station with the woman and help her to file the case. The Mitanins feel that going to the police is not very useful as it results in further harassment of the victim, however success in a few cases resulting in penal action has a demonstration effect in the area and acts as a threat. Once the woman decides to go to the police, the Mitanin tries to ensure that the police takes the complaint seriously and does not harass the woman. She also pressurises the police to take action against the accused.

"The police harass people who are not able to speak up. I have helped many cases in the police station……One should face up to the police also...they are after all humans, not god or anything. They can't be allowed to be so arbitrary"(Mitanin Trainer Interview, Kachod).

"The first time I ever went inside a police station was with a case of violence"(Mitanin Interview, Kerabehera).

"Sometimes they take bribe from the other party and don't act. We pressurise them to act" (Mitanin Trainer Group Interview, Manendragarh).

The Mitanins follow up on past cases during their village meetings. They also keep meeting the women and asking them whether all is fine. During cluster meetings of the Mitanins, the Mitanin Trainers also review whether any new cases have emerged. This helps to keep a focus on this issue, along with others.

Action taken by the Mitanins in specific cases of violence against women has served as a warning to other men. This has also instilled confidence in women being subjected to violence, to ask for help. The men are now aware that the women can easily go to the Mitanin or to the police. The Mitanins show their modules and books to the men in the village and this legitimises the action and also acts as a threat to the men against inflicting violence.

"Unko pata hai yeh kaam bhi hum karte hain" (Men know that we [Mitanins] also work on these issues) (Mitanin Interview 2, Rokda).

4.3.5: Changes that have come about in situation of violence against women

Ever since the Mitanins have started working on violence against women, there has been a decrease in violence in the villages. Women felt that there has been a lot of improvement in women's lives after the Mitanin programme was introduced.

"Mitanins have made the village safe for women"(Mitanin Inteview, Gundru).

"Abhi purush log mahilaon ko utna pareshan nahi kar paate hain aur atyachaar bhi utna nahi karte hain" (Now men are not able to harass women as much and they also don't inflict so much violence on women) (Mitanin Interview 1, Rokda).

"*Women have gained strength from the Mitanins"(District Coordinator Interview, Koriya).*

Although there was an existing law against violence, and laws against various forms of discrimination against women, women were not aware of them. Women became aware of the existence of these laws and more importantly, they became aware of the right not to be subjected to violence, even by family members. This empowered the women and persuaded them to act against any violation of their rights.

"Now there is a Law to keep women secure in their homes" (Mitanin Interview, Machidand).

More and more women now speak out about their abuse after few incidents. They threaten the man that they will go and complain to the Mitanin unless he stops hitting.

Neighbours, especially women, now help any women being subjected to violence. They stop her from getting hit and help her to reach the Mitanins for help. As a result of this, men too have become more cautious. Cases of husbands throwing out their wives from their house have reduced significantly. As one Mitanin said:

"Men can no longer do as they please, now they are scared"(Community Group Interview, Badkabehera).

"*Small fights do keep going on even now but women still don't do to the police. She tries to improve her situation herself at home. When it becomes too much for the woman, she comes to us and says that he does not listen to me, please make him understand. Earlier women had no rights, but still would try to talk to husband. But that time husbands would not at all listen to their wives. Now some listen and then stop because they think if they don't listen, their wife may take some action against them."(Community Group Interview, Rokda).*

Although overall violence has decreased but it still exists especially when men drink. Moreover, Mitanins themselves stated that many incidents of violence still remain hidden.

Mitanins have compelled service providers like the police to respond adequately to the community. Mitanins have been helping women to file complaints with the police. They talk to the police and negotiate with them even though the police may try to intimidate them sometimes. The police also now listen to what the woman has to say and helps them.

"Now we know what the inside of a police station looks like; we know everything about the police"(Mitanin Interview, Kerabehera).

"Women have lost their fear of the police"(Mitanin Trainer Group Interview, Manendragarh).

"Couple of boys had entered a woman's house. Many people, including the village council head tried to get the police to come for three days, but they did not come to arrest the boys. The woman and her family came to me. They said please take us to police. I went and police asked why have you come? I said because you are not doing your work. They made us wait and brought the boys from the village. They asked the woman what the problem is. She was not able to explain properly. The police were trying to make a case that she herself had called the boys to her house. I took her outside and told her to speak up and explain properly and completely refute the charges that she had called them home. I told her if you don't say anything then what can I do? Then she spoke up very boldly and refuted all charges put by the boys. Then the police scolded the boys and put them in jail. Their parents gave Rs. 5000 each to the police and freed the boys. The parents said if we have spent this money, we will take the woman for one day. I told her that if anyone tries to molest her, to make a lot of noise. I also told the police that you are letting them go but if they try anything I will take it up to higher authorities. The police told the boys that if you again do something like this the Mitanin will take this case up to higher authorities then even I can't do anything. Now I am leaving you on bail. Till date she has not been troubled again" (Mitanin Trainer Group Interview, Manendragarh).

"The police recently came and said that they want to form a village committee to deal with cases at the village level so that all cases don't need to reach the police. The committee can call the police only if and when it is required. They selected two Mitanins in it out of seven members"(Mitanin interview1, Rokda).

There has been an overall reduction in gender discrimination in the villages due to the Mitanins. Child marriages rarely occur. The Mitanins and other women are called to participate in village and community meetings. They are able to contribute equally to discussions and decisions in the meeting. For the Mitanins themselves, this has been a process of self-empowerment. One indication of improved gender status is the rise in both adult and child (0-6 years) sex ratio in the rural areas of the district in the last decade, which is the highest increase in the state, while most districts have seen a decline[3].

"Mitanin programme has been more advantageous for women than men. We [men and women] sit and discuss as equals"(Community Group Interview, Badkabehera).

"Earlier I never went anywhere. Now I go for meetings and I learn new things"(Mitanin Interview, Machidand).

The Mitanin's work is now recognised by the village elders, people's representatives and other community people who would previously chide them. The Mitanins have forced them and local governance structures like the village councils to intervene in

[3] Sex Ratio is calculated as number of females per 1000 males. The adult sex ratio for rural areas in Koriya district increased from 971 in 2001 to 989 in 2010. The child sex ratio for rural areas in Koriya district increased from 978 in 2001 to 987 in 2010 (Census, 2011).

such matters. They in turn also seek help from the Mitanins on a variety of issues. Many Mitanins have also been elected to these councils. State wide, 23rd November 2011 was celebrated as 'Day of the Mitanin'. On that day, in many villages in Manendragarh Mitanins were awarded by the community and village councils for their work.

"Council head helps us. They call Mitanins to all meetings. They presented awards the Mitanins during 'Mitanin Day'. A lot of respect is given to Mitanins"(Mitanin Trainer Group Interview, Manendragarh).

Now the police also elicit support from the Mitanins and ask their advice in some cases. One Mitanin narrates, *"Girl and boy were having an affair. He started suspecting her with another and hit her very badly. Her parents went to the police. The police telephoned me asking me what the case was about. I told him the story. I told him that you catch the boy but leave the girl alone. They then put the boy in jail for 5-6 months" (Mitanin Interview, Kerabehera).*

The Mitanins have gained the trust of the community. They believe that Mitanins do good work and are always successful. This has made the socially, economically, politically more powerful groups wary of the Mitanins and deters them from carrying out too much excesses.

"Mitanin ki baat zindabad hoti hai.....Toh woh hamari ekta se dartey hain" (Whichever issue the Mitanin takes up, she is triumphant in that, so they now fear our unity) (Community Group Interview, Badkabehera).

4.3.6: Challenges faced

Along with the positive outcomes, the Mitanins and the rest of the women have had to face various challenges in the process of acting on the issue of violence against women.

As with all other work on gender rights, men inflicting violence consider this as a threat to their dominance. In this case too men attempt to belittle the Mitanin and their work and harass them in any way they can. As one Mitanin said, *"Women understand this work, not men"(Mitanin Interview, Kariabehera).* There have been cases where the police cases have been filed against the victim and the Mitanin by the perpetrator. As a result, the victim and Mitanin have to face a lot of harassment like having to go for regular court hearings.

Even though more and more women speak up against domestic violence, they are still under threat from their husbands. This deters them from asking for help.

"The husband threatens the victim that he will kick her out if she tells Mitanin, so many women don't come"(Mitanin Interview 1, Rokda).

A major threat to the Mitanins' work on determinants of health, as identified by the District coordinator, is the pressure of fulfilling targets for government health workers. Health workers are given targets on various aspects, like family planning, delivery in facilities, and identification of patients of Tuberculosis/Leprosy/Cataract, which they then force the Mitanins to fulfill. This gives the Mitanins less time to

undertake rights based work and she is forced to function simply as a health service provider.

However, despite these challenges, Mitanins of Manendragarh have continued to take action on violence against women. They are now eager to start a campaign for banning alcohol in the whole area. The work on violence will hopefully get a boost from the latest round of training, the sixteenth round which is a revision of the women's health module with new components like laws on domestic violence, sexual harassment, dowry, and property rights.

As a Mitanin Trainer, who used to be a Mitanin herself and has been a pioneer in the action on violence against women in Manendragarh, stated forcefully:

"This work has to go on and we should not get scared. If we get scared then violence will increase. We have to expand this work. If we leave doing this work people will not take us seriously and make fun of us say they worked on this for some time and now have become scared. We have started working on this and should not do back down. We have to persist. Earlier the police never listened to women, now they do. We will undo all the work and become weak if we leave this work now" (Mitanin Trainer Interview, Kachod).

CHAPTER 5. CROSS LEARNING AND DISCUSSION

In this section, the attempt is to integrate learning from both case studies; the perspectives of the state level programme leadership and discuss them with relation to existing evidence. As per the objectives of the study, the specific questions, which I propose to explore here, are; what was situation before regarding the social determinant and what changed; what were the catalysts for action; what role has emerged for the Mitanins; and finally, what was the process of action on social determinants and the challenges faced.

5.1: What was situation before and what changed?

In both case studies, an attempt has been made to understand the situation existing with regards to the social determinant under study before the Mitanins started addressing it. It is interesting to note that in addition to describing the existing situation and the later impact on the particular social determinant per se, both the community and Mitanins articulated their own situation or status (as individuals, as women, and as Mitanin), which existed before they started working on these determinants and described how that changed. In case of the Mitanin, this reflects that she identifies herself completely with the community.

The respondents spoke of the low status that was awarded to women in their society and the ensuing gender discrimination. Violence against women (in case of Manendragarh) and denial of food to women (in case of Durgkondal) were manifestations of this. In both cases women spoke about not being allowed to attend village meetings and of being alienated from any decision making process within the community.

With regards to the specific social determinants, the respondents in both cases emphasised that they were not aware of the relevant information or of their rights or entitlements in the matter. This led to a status quo in the existing situation- that of continuing violence by men and suffering by women in case of Manendragarh and that of lack of access to food, non-functional programmes and low nutritional status in Durgkondal. The respondents spoke of the lack of support and in fact, sometimes harassment from village councils and administrative structures. In Manendragarh the feelings of helplessness and hopelessness was more intense, perhaps due to the nature of issue under study.

Both case studies show that there has been a significant improvement in the status of the social determinants. In case of Manendragarh, there has been a decrease of violence against women, as articulated by the women themselves. In Durgkondal, the food programmes are functioning better and access of the community to them has increased. In both cases, there seems to have been a marked improvement in the lives of women. Women, who would feel helpless previously, now have a support system, which they can access incase of violence or denial of food. Though the level of empowerment of the Mitanins is much higher than that of other women, nonetheless, now many women are able to assert themselves both within their family and in the community. Solidarity building amongst Mitanins and other women has aided this.

In both cases women have expressed how access to information about their rights have helped them to access them. The village councils and government workers seem to be more responsive, however, certain amount of antagonism towards the Mitanin and other women remain. This is true also for men vis-a-vis the issue of violence.

The Mitanins have been able to bring about some change in the balance of power in favour of women and the poor in the community and village. Both cases show that a wider social change in decrease of gender discrimination was brought about due to the Mitanin's overall work in the village. In both places, women now attend village meetings, intervene appropriately and partake in community decision-making. The Mitanins are respected and recognised for her work.

The various outcomes of the Mitanin programme, both in the field of healthcare and social determinants have been documented through articles, reports and independent survey data (Nandi, 2005; Batiwalla, 2007; Sundararaman, 2007; Sanders, 2008; Rajshekhar, 2010; EUSPP, 2011; Dasgupta, 2012).

5.2: What were the catalysts for action?

5.2.1: Definition of health and role of the Mitanin in the programme

Programmes are 'theories' and their vision for change determines the mechanisms or the 'apparatus' (Pawson & Tilley, 2004). Therefore, in discussing the catalyst for action first it is important to first explore the definition of health and the role of the Mitanins as envisaged in the programme.

The case studies show that health has been defined in the programme in a very comprehensive manner, encompassing social determinants like gender, violence against women, and nutrition and has dealt with issues like health inequity, rights and entitlements. The Mitanins themselves also articulated this. This is in consonance with the vision of the programme, as articulated in the initial documents. The Mitanin Programme was formulated within the framework of PHC and aimed to address health inequity through action both on the health system and social determinants

(SHRC, 2003a). Therefore Mitanins were envisaged as 'activists', who would address issues of the poor and marginalized and lead the social process of their empowerment (SHRC, 2003a). This is reflected in both case studies.

Defining health and their role in this manner has prompted the Mitanins to work on social determinants of health, along with healthcare work. The role visualized in the initial documents, have been followed up with, in the programme design, including selection, training and ongoing support, and systems of accountability and remuneration. These aspects will be discussed one by one.

5.2.2: Selection

The Mitanins' selection process in both blocks was similar. The Mobilisers organized meetings in the villages and people suggested names of women who could become Mitanins. Consultations were also held with the village council members to identify a name. However, often women themselves did not participate in the meetings.

In both places considerations like mobility, ability to speak, leadership qualities, availability of time, and family obligations, along with her being from the same village and of the same socio-economic profile, were taken into account by the community while selecting. However, in Durgkondal, there seems to have been more emphasis on literacy levels while on the other hand, literacy level does not seem to be of consideration in selection in Manendragarh as most of the Mitanins and even a few Trainers are not literate. This might just be a reflection of the differences in literacy levels of women in the districts at the time of selection, with Kanker having nearly 20% higher literacy rate than Koriya district[4] (Census, 2011). State programme

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[4] In 2001, literacy rate of rural women was 63% in Kanker district (for Durgkondal), while in Koriya district (for Manendragarh) it was 42% (Census, 2001).

officials add that while hamlet-based selection mostly ensured that the Mitanin was of the same socio-economic profile, the lack of payment made it unattractive for 'village elites' to take up this position (SHRC State official Interview). Therefore, from the study it has emerged that that selection by the community (Sanders, 1990), with a flexible criteria (Krishnamurthy & Zaidi, 2005) led to many women having existing leadership qualities or interest in community work being selected through their reputation (Schultz *et al*, 2002), self interest (Schultz *et al*, 2002) or reflection by the community (Krishnamurthy & Zaidi, 2005).

The above findings are in congruence with the selection criteria and process outlined in the Mitanin operational guidelines (SHRC, 2003a: 61):

"The selection of the Mitanin is by a dialogue between the projects facilitator and the local community…………The Mitanin should be a woman. Preferably a woman who is married and who would be supported by the family in this work. Since motivation is important any woman who has been the past associated with voluntary work for the betterment of the village would be a good choice. This is something we have to enquire about. If no such woman is there we need to ask whether there is a young woman who is willing to come forward for voluntary work. We should mention that we are looking for a woman who would be able to develop as a leader, as an organiser…………The Mitanins educational level is not a criterion. However a good level of literacy would be most desirable".

It is pertinent to note that in both places, many Mitanins later became Mitanin Trainers and Trainers in turn were promoted as Block Coordinators. In both blocks under study, the respective District Coordinators had previously been Block Coordinators. This seems to reflect the quality of human resource and the dynamic

nature of the programme. The Mitanin's attrition rate of 2.5% (SHRC State official Interview) as against rates of 3.2% to 77% quoted in literature (Lehmann & Sanders, 2007), could also signify the efficacy of the selection procedure, amongst other facilitative processes.

5.2.3: Training and on going support

From both case studies it is evident that training has greatly facilitated the Mitanin's work on the social determinants. As the Mitanins expressed, it was the first indication to the Mitanin to start working on these issues. The Training design has led to building perspective, skill, and imparting knowledge and information about the issue. The training materials seem to have great significance as they have been used by Mitanins to establish the legitimacy of their work and information they impart on social determinants. They were also used as a pressure tool with the service providers (in Durgkondal) and with the perpetrators of violence (in Manendragarh). These findings corroborate that of other studies, which find that training is the most critical element of the programme that builds interest, skills, confidence and credibility (Krishnamurthy & Zaidi, 2005), legitimacy and leadership (Ingram *et al*, 2008).

The case studies show that the system of on the job training through meetings and field level support to direct action by the support structure has been instrumental in sustaining action on the social determinant. The support structure has an important role in training the Mitanin, and providing handholding and on the job support. The Mitanins also turn to them for advice when faced with difficulties. They seem to be involved along with the Mitanins, in all their interventions. The other component that emerged was the reinforcement of the above through regular meetings. Cluster

Meetings of the Mitanins are used for knowledge transfer, cross learning, discussing issues, problem resolution, and planning for action.

The importance of ongoing training and on-the job support to the CHWs as illustrated in the case studies is emphasised by various scholars (Bender &Pitkin, 1987; Schultz *et al*, 2002; Lehmann *et al*, 2004; Krishnamurthy & Zaidi, 2005) along with the significance of regular meetings (Schultz *et al*, 2002), supportive supervision (Van Ginneken *et al*, 2010) and mentoring (Ingram *et al*, 2008).

Researchers have stated the relevance of the use of social drama (Lehmann *et al*, 2004; Farquhar *et al*, 2005), culturally sensitive messages (Schultz *et al,* 2002) and songs (Lehmann *et al*, 2004). In the Mitanin Programme too, the use of social media like role-plays and songs during trainings and meetings helped to "build and retain a sense of mutual solidarity" and "paint a popular image of the Mitanin in the local idiom" (Rajshekhar, 2010).

The reporting format used in the monitoring information system (MIS) of the programme was reviewed by the author. In addition to the Mitanins healthcare work, this monthly format attempts to capture action on social determinants, like number of Mitanins intervening in domestic violence cases and food security issues, and the processes, like number of village or cluster meetings held. It is pertinent that action on social determinants is reported and tracked as a part of the regular reporting and monitoring system, however, the role of the MIS of the programme in facilitating and documenting action on social determinants was not explored in Blocks during the study.

5.2.4: Accountability and payment

Significant issues related to payment and accountability emerged from the case studies, which have been corroborated by available documents and state level programme persons. In the case studies, the participants have not referred to any significant role played by the health department staff either in their action on social determinants though this may be because most questions were related to social determinants and not health care or health services. In selection, only in some instances, and that too in selection procedure of Mitanin Trainers and Block Coordinators and not Mitanins, were the health staff mentioned. In fact, in both studies most of the health system is referred to, is when the participants speak of monitoring health services and demanding health services. This reflects the design of the programme, which sees the health department only in a supportive role and not in a monitoring or supervisory role (SHRC, 2003a).

From the stage of selection to implementation of the programme, emphasis has been given consciously on the role of the village councils even though the democratic functioning of these councils is of concern (SHRC, 2003a). However, this has helped in fixing accountability of the Mitanins to the community rather than the health department and giving her autonomy. Moreover, persons who are part of the reporting structure of the Mitanins, like Mitanin Trainers, Block Coordinators and District Coordinators, though paid by the government, are part of civil society.

The Mitanins do not receive regular payment. They get incentives from the health department for various healthcare/service related tasks, like mobilization for immunization, and motivating pregnant woman to deliver at the facility, however these incentives are miniscule and not regular. Though there is an obvious sense of

being denied financial reward among the Mitanins and their well wishers, many at the higher level of the progamme feel that not getting regular payment has been one of the factors which have allowed Mitanins to retain their autonomy and prevented them from becoming the lowest rung of the health department. Highlighting the right of the Mitanins to receive remuneration for their work while retaining their autonomy from the department, the SHRC has recommended giving funds to the village councils for payment to the Mitanins. Though there is political will for this, the health bureaucracy is not willing to give up its power. Emphasising its commitment to the Mitanin programme, the Government of Chhattisgarh has initiated the 'Mitanin Welfare Fund' under the stewardship of SHRC to implement social security measures for Mitanins like health insurance, life insurance of husband, pensions, and scholarships for education of their children, and income generation initiatives. The Government has also sponsored Mitanins as candidates for ANM (Auxiliary Nurse and Midwife) and Staff Nurse courses, visualizing such career paths for Mitanins who have the requisite educational qualifications (SHRC State official Interview).

Many scholars have commented on the accountability and remuneration structures, as this remains a conflict area even in the case of pure healthcare work. Their design becomes more critical when addressing social determinants, as they can become facilitating or constraining factors in this action. Bender & Pitkin (1987) state that accountability is related to who pays the CHW. Scholars exploring CHW's work on social determinants are of the opinion that accountability of the CHW should be to the community, especially the poor and not to the health department (Sanders, 1990) or else they will be relegated to being the lowest rung of the health department (Van Ginneken *et al,* 2010). Moreover, the role of autonomy and flexibility in work in facilitating the work of CHWs on social determinants has emerged in other research

(Werner, 1977; Ingram *et al*, 2008). As Ginneken *et al* (2010) found, when CHWs were placed in health centers instead of the community, they were no longer accountable to the community and many missed the flexibility of their work.

5.2.5: Significance of the Mitanin's work to the community

Mitanins in both case studies were acting on issues relevant to their own lives and the community's. Dealing with issues that would lead to improvements in their own lives acted as a motivation for them and the community to continue striving till they succeeded. Being part of the same community enables them to identify and intervene in the most critical aspects of their lives. Perez & Martinez (2008) found that CHWs are the best persons to understand the community's needs and deals with the most essential services and rights.

Being successful in other work built the community's trust and confidence on the Mitanins, facilitating their work on social determinants. One critical component of this is has been securing good health for the community, especially women and children through her healthcare work. As Sanders (1985, quoted in Lehmann *et al*, 2004:11-12) argues, "equipping VHWs with curative skills does not simply provide health care to more people, more quickly and more cheaply, but it also gives the VHW greater credibility in the eyes of the community". In addition to providing healthcare and health education, the Mitanins were also engaged in ensuring effective delivery of health services by the department and improving access of the community to those services, through monitoring of those services and intervening incase of any gap or denial. The Mitanin's healthcare work has been widely recognized and documented (Nandi, 2005; Batiwalla, 2007; Sundararaman, 2007; Rajshekhar, 2010; Dasgupta, 2012). Moreover, the Manendragarh case study and related articles show

that the Mitanin's successful efforts on various social determinants like nutrition and forests helped them to build an organization to take action on any social determinant (Nandi, 2005; Sanders, 2008; Dasgupta, 2012).

5.2.6: Environmental factors

From both studies certain environmental factors emerge, which may have contributed to the action on social determinants. One aspect that has been repeatedly stated in many studies is that of the socio-economic, cultural and political situation of the area. The CHW's work on social determinants has been highlighted especially in the marginalized and disadvantaged communities (Perez & Martinez, 2008; Farquhar *et al*, 2005). The severity of existing issues like occurrence of political and social injustices (Van Ginneken *et al*, 2010) and repression (Labonte, 2010) has also been found to be a catalyst for action on social determinants. Both blocks under study are tribal areas. Tribal areas are marked by impoverishment, marginalization; and exploitation by the socially and economically dominant groups. This is reflected in their low health and nutrition status (PHRN, 2010). In terms of gender, even though in tribal societies, women have traditionally enjoyed relatively better status than in non-tribal societies, severe issues of discrimination, violence and denial of rights exist (PHRN, 2010). Moreover, the role of the existing systems of conflict resolution, as in the case of Durgkondal and the relative openness in society, as in the case of Manendragarh, have emerged from the case studies. However, as no non-tribal area was studied, it can only be suggested that these aspects may have prompted and facilitated the Mitanin's action on social determinants and that this requires further enquiry.

Complementary initiatives, like the Nutrition Fellow initiative in Durgkondal and the initiative on tribal rights in Manendragarh and exposure to larger campaigns on food rights and gender rights would also have strengthened the Mitanin's work in these blocks. This highlights the role of civil society networks in supporting the CHW's work on social determinants (SHRC, 2003a).

5.3: What role has emerged for the Mitanins?

Before describing the process of action, it is important at this point of time to discuss the role for the Mitanins that has emerged from the two case studies.

From both case studies, it emerges that the Mitanins are working on a range of issues. In both blocks the Mitanins are engaged in healthcare work, which includes motivating for immunization, promoting safe deliveries for women, taking care of pregnant and lactating women and neonates, providing primary treatment, and demanding regular services from the health staff and health facilities. They are also working on various social determinants like malnutrition, monitoring of food schemes, gender issues, banning of alcohol and violence against women. In Manendragarh, they have also worked on forest rights and against deforestation. In terms of issues being dealt by CHWs, existing literature has talked of both health issues and social determinants. In terms of social determinants, scholars have studied the CHW's work on advocacy (Labonte, 2010), human rights (Van Ginneken *et al*, 2010), health inequity (Prasad & Muraleedharan, 2007), economic, social, environmental, and political rights (Perez & Martinez, 2008), poverty, employment, housing, and discrimination (Ingram *et al*, 2008), nutrition and empowerment (Becker *et al*, 2004; Wallerstein, 2006; Prasad & Muraleedharan, 2007).

In the case studies there emerge two types of roles of the Mitanins, which are described and illustrated in two types of interactions as follows:

5.3.1: Role as a change agent within the community

The first interaction of the Mitanins is with the community, which includes the villagers and the social context in which they live. The Mitanins have built awareness and understanding within the community, including of community-based institutions like village councils, on malnutrition, violence against women, entitlements of the community, and role of the service providers. The Mitanins also seem to have played an important role in bringing about some change in attitudes and practices, mainly against the disadvantaged groups, within the community and in the village councils. They have also compelled the community to respond to the problems and needs of the disadvantaged groups either voluntarily or under pressure. This has resulted in lesser gender discrimination, change in discriminatory practices against women like denial of food, inflicting violence, and non-participation in community decision-making. The nature of awareness building along with capacitating and enabling people to act on the social determinant seems to be akin to what Freire (1996) described as 'conscientization'[5].

The role of CHWs in educating, and empowering the community has been considered critical in work on social determinants (Werner, 1977; Becker *et al*, 2004; Wallerstein, 2006; Prasad & Muraleedharan, 2007; Labonte, 2010).

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[5] "The term 'conscientization' refers to learning to perceive social, political and economic contradictions, and to take action against the oppressive elements of reality-Translator's note" (Freire, 1996:17).

5.3.2: Role as an advocate for the community

The second interaction of the Mitanin is with persons, and institutions beyond her village. In the case studies, this included the police, government departments, and workers and service providers under the food schemes of the government. In this role, the Mitanin, along with other villagers or on her own, pressurises or negotiates with them on responding to the people's problems or providing the entitled service.

Various scholars in their research have found the CHWs to be playing this critical role in the action on social determinants. This role of the CHWs has been articulated in various ways as; articulating people's concerns and being a 'vehicle for social justice' (Perez & Martinez, 2008), linking people to various services (Perez & Martinez, 2008), advocacy (Ingram *et al*, 2008), and political activism (Van Ginneken *et al*, 2010).

From both case studies it emerges that most of the women consider the Mitanin as someone knowledgeable and able to give correct and good advice. She is considered as someone who speaks up and acts on all rights, though her legitimacy to do this is questioned by the perpetrators or the more powerful people in the village. However, for most of the women and the poor, she is someone who is available at all times to help everybody. She is the person who listens to them and takes necessary and decisive actions. She is also seen to be successful in anything she intervenes in. She is seen as intervening on behalf of the disadvantaged. The Mitanin too seems to have a similar self-image, which motivates her to play the role people now expect her to play. These relate to the profile and roles of CHWs as envisaged by various scholars and described above.

5.4: How did the changes come about?

One of the objectives of the present study was to describe the process of the Mitanin's action on social determinants. Though separate social determinants were studied, the process of taking action was very similar in the two case studies. In both cases similar strategies of community mobilisation were employed. Components of the programme design like trainings, meetings at various levels and the support structure facilitated this process. The process of action on social determinants that has emerged from the two case studies could be enumerated as follows:

- Building awareness and understanding about the issue of the community, service providers and related institutions

- Organising and uniting the community, especially women

- Mobilising the community to intervene in an issue or demand rights and entitlements

- Spontaneous/intuitive action against an immediate problem/denial

- Eliciting help from the Mitanin support structure like Mitanin Trainers and Block Coordinators

- Eliciting support from external persons/agencies like ICDS worker, supportive government staff

- Use of local governance structures like village councils

- Use of government administrative structures like police, various departments

- Relentless action and follow up till outcome is satisfactory

- Drawing strength from supportive network like other initiatives and campaigns

Unfortunately, very few researchers have described the process of action on social determinants by the CHWs. Ingram *et al* (2008) throughout their paper suggest various processes, like awareness building, uniting and mobilising people, influencing decisions and solving problems. Schultz *et al* (2002) describes the process of forming groups, developing priorities, working with other agencies, and intervening.

5.5: Challenges faced

The CSHD (2007:17-18) document states "….action on the social determinants of health inequities is a political process that engages both the agency of disadvantaged communities and the responsibility of the state. This political process is likely to be contentious in most contexts, since it will be seen as pitting the interests of social groups against each other in a struggle for power and control of resources". In both case studies it has been found that the Mitanins and the women when acting on social determinants, are often subject to harassment by the 'village elite' or by government workers who face the possibility of losing some amount of power, privilege and even economic advantage.

A threat to the Mitanin's work on social determinants that emerged was of undue pressure exerted by government workers on Mitanins to fulfill their healthcare targets. This, along with demand for government employment for Mitanin by certain groups for their own political interest, threatens to discourage any action on social determinants. Many researchers like Sanders (1990), Lehmann *et al* (2004), and Van Ginneken *et al* (2010) have articulated this threat. Van Ginneken *et al* (2010) find in their study that CHWs are getting isolated from the community due to increasing over-medicalisation of CHW programmes.

This brings us to one of the critical factors, which contributed to the success of the programme and the challenges faced therewith. Overall, the single most important factor in the success of programme has been the facilitation by the State Health Resource Centre. The fact that the programme was situated within an autonomous institution rather than the government department, contributed greatly to the way the programme has emerged and the roles the Mitanins have played with respect to both healthcare and social determinants. However, maintaining autonomy of the programme (and therefore of the Mitanins) in the face of increasing institutionalization of programme within the health department is a huge challenge for SHRC (SHRC State official Interview). For a programme, which was initially slated to run for 18 months and instead has crossed its 10th year of implementation, there is a certain requirement for institutionalizing norms, procedures and rules in order to function effectively. However, it is a constant struggle for SHRC to try and institutionalise it within the community rather than the government. This is exacerbated by the fact that attempts are being made to unionise the Mitanins to demand government employment. This is however happening more in the plains, non-tribal, and mainstream areas.

The Mitanin Evaluation document states, that “there is compelling evidence that the original programme design has produced the intended results”, however it also warns of the threats to the ‘original’ design (EUSPP, 2011). It emphasizes that Mitanins should “continue to be treated as volunteers and no duties should be imposed” and recommends, that “a community led/owned compensation system be evolved” for the Mitanins (EUSPP, 2011:83-84). Recent developments show a positive move forward in dealing with this issue. In the State Health Society General Body, the highest decision making body on health in the state, in April 2012, decisions have been made

to place accountability of the Mitanin with the *panchayats* (village councils) and to make all payments to the Mitanins through the *panchayats* (State Health Society GB Minutes, 2012). This will be started as a pilot project in a few places.

The case studies show that despite these challenges, the Mitanins and the community believe that their work on the social determinants is not complete and they emphasise on the need to continue working on them.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1: Conclusions

The aim of the study was to describe the role of Mitanins in addressing social determinants and to describe the pathways through which this happened. The study confirmed that the Mitanins in Durgkondal and Manendragarh have effectively and successfully addressed the issues of nutrition and violence against women as social determinants, in a manner visualized in the initial programme documents. Moreover, despite threats to the autonomy of the programme, pressures to formalise the Mitanin's role and backlash from vested interests, such action remains sustained, nearly 10 years after the inception of the programme. Mitanins have gained recognition as 'agents of change' and as 'advocates for the community'. The community considers her as someone who is knowledgeable, just, and available, who articulates the demands and defends the rights of the poor and marginalized.

The two case studies throw up factors, roles and processes in the action on social determinants. This is illustrated in an explanatory framework below (Figure 4).

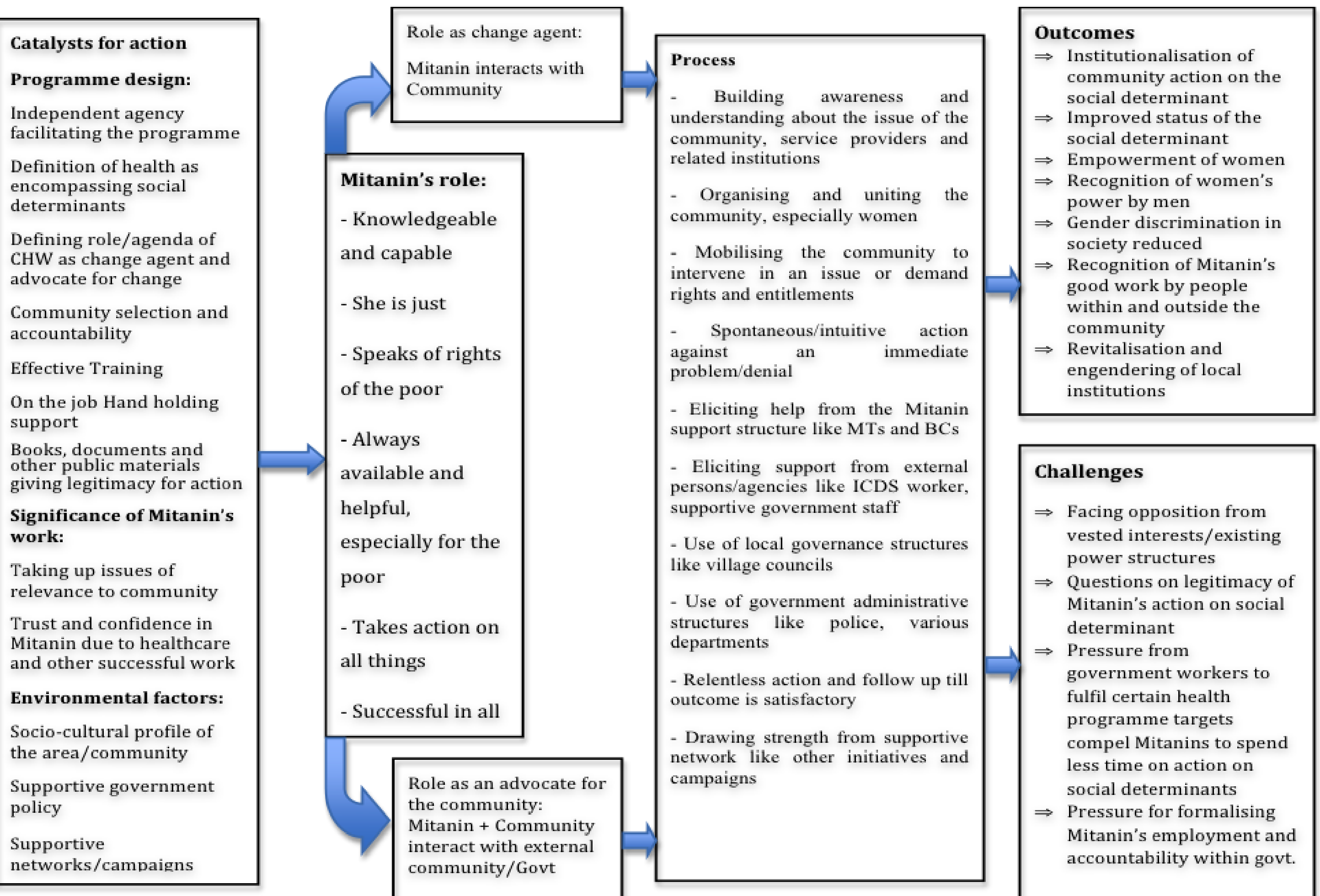

Figure 4- Explanatory Framework for Mitanin's action on social determinants

The framework shows that the Mitanin programme design, along with the way the Mitanins responded to the community's needs and certain environmental factors acted as catalysts for the Mitanins to act on the social determinants. It also shows that the design of the Mitanin programme was determined by the way the Mitanin's role was visualised at the beginning of the programme and this is in turn got reflected in every aspect of programme implementation like selection, training, supervision, support, remuneration, and accountability. The process of action on social determinants was very similar in both cases even though the determinants being studied were different. It followed various processes of community mobilization and social action within the community and vis-à-vis the government and service providers. A significant outcome, which emerged was with respect to the community-based institutions like the village councils, which appear to have been revitalized and more equally "gendered" as a result of the process of Mitanin's action.

The latest Mitanin Evaluation document recommends that, "Mitanins' role in mobilizing communities on social determinants of health like poverty, gender, nutrition, sanitation etc. should be actively encouraged" (EUSPP, 2011). The current study illustrates very clearly the significance of the 'intent' of a programme reflected in its design and subsequently in all its processes. The need for working on the social determinants of health is very real and urgent and community health workers can play a significant role in such action on social determinants. Therefore, CHW programmes need to, from the beginning, be formulated within the framework of comprehensive primary health care and with the intent of addressing the social determinants of health. CHWs themselves need to be supported in a sustained manner and accorded

some degree of autonomy to successfully act as a change agent and as an advocate for the community.

Being a qualitative study, the results are not narrowly generalisable to the study population; however, the explanatory framework that has emerged from the study may be used for 'analytical generalisation', in raising general lessons for programmes in similar contexts.

The study suggests lessons for further development of the Mitanin and ASHA Programmes in India, and more generally, CHW programmes interested in addressing social determinants and visualising an 'activist' role for the CHW.

These are:

6.2.1: Recommendations for the Mitanin Programme

1. The various factors acting as catalysts for Mitanin's action on social determinants have to be protected, reiterated and strengthened. These include:

i. Maintaining autonomy of facilitating agency (SHRC)
ii. Reiteration of comprehensive definition of health as encompassing social determinants, in all programme components like training, and monitoring, in future as well.
iii. Protecting the role of Mitanin as change agent and advocate for change
iv. Reiterating and protecting the autonomy of the Mitanin and flexibility in her work
v. Strengthening the community-based and programmatic meetings at various levels
vi. Building further capacities of SHRC staff and the Mitanin support system on providing support to action on various social determinants

2. Systems for further "communitisation" of the programme have to be introduced. These include:

i. Emphasising and operationalising accountability of the Mitanin to the community rather than the government departments
ii. Further integration of *panchayats* (village councils) in programme support and monitoring
iii. Ensuring remuneration for the Mitanins through the community or community-based institutions
iv. Desisting any attempts to formalize or institutionalise the Mitanins within the public health system
v. Promoting further autonomy for the Mitanin support structure

3. Orientation of government personnel working in the public health system, district and block administration and government departments dealing with social determinants of health, from the village to the state level, has to be undertaken on the following issues:

i. Role of the Mitanins as a change agent and an advocate for change
ii. Mitanin's accountability towards the community
iii. Importance of autonomy and flexibility in the Mitanin's work
iv. Significance of Mitanin's action on social determinants of health

4. Lessons from areas where Mitanins have successfully acted upon social determinants should be used to promote such action in other areas

5. The Mitanin's work on social determinants needs to be documented as part of regular programme monitoring and documentation and disseminated widely.

6.2.2: Recommendations for the ASHA Programme towards addressing social determinants of health

1. The definition of health as encompassing social determinants has to be reiterated in all components and processes of the ASHA programme
2. The role of ASHA as change agent and an advocate for the community has to be promoted
3. Understanding and action on social determinants has to be integrated in all programme processes, including training, home visits, village meetings, programme meetings, documentation and review and monitoring
4. The ASHA curriculum needs to include perspectives, skills, and knowledge and information about various social determinants of health.
5. A strong and autonomous support structure involving civil society partners has to be introduced in states where it is not there and strengthened in states, which already have a support system
6. On the job training and field level support to direct action has to be done by the support structure in action on social determinant.
7. Systems of accountability and remuneration for the ASHA have to be community-based
8. Autonomy and flexibility in the ASHA's role and work has to be promoted
9. Successful health care work has to be encouraged in order to build confidence amongst the community
10. Programme monitoring and evaluation should include monitoring indicators and outcomes on social determinants
11. The government departments dealing with various social determinants have to be oriented on the ASHA's role vis-à-vis social determinants of health

12. The ASHA's should be exposed to supportive networks/ campaigns, which could in turn support their work on social determinants

6.2.3: Recommendations about the design of CHW programmes to better address social determinants

1. Selection of the CHW has to be done through a facilitated process within the community with flexibility in criteria for selection
2. The programme, though might be a government one, should be facilitated by an autonomous agency or with help from civil society partners
3. The programme should necessarily, from the beginning define health in a holistic manner, encompassing social determinants
4. The programme should visualize the role of the CHW as a change agent and advocate for change from the beginning
5. The Training Curriculum has to specifically include building perspectives, knowledge and skills with regards to action on social determinants
6. Training materials should contain details of entitlements, rules and guidelines with respect to social determinants, giving legitimacy for action and to be used as a negotiation or pressure tool
7. Systems of accountability of the CHW have to lie with the community rather than with the government department
8. Remuneration to the CHW should be given through community- based processes
9. Mentoring and on the job hand holding support to action on social determinants has to be designed and implemented
10. The CHW's work on providing healthcare or access to health services has to be successful in order to build the confidence of the community

11. Government policies on various social determinants need to be supportive to the work on social determinants of health
12. The CHWs should be exposed to supportive networks/ campaigns, which could in turn support their work

6.2.4: Future research avenues

Further research on the Mitanin and the ASHA programmes, both qualitative and quantitative, should be undertaken, exploring the various themes that have emerged in the study. The explanatory framework could be used in future research on CHWs and their action on social determinants and be reviewed and modified thereafter.

REFERENCES

Batiwalla L. (2007). Mitanins: Chhattisgarh's 'barefoot doctors'. *InfoChange News and Features*. [Online], Available: www.infochangeindia.org [Downloaded: March 24, 2011 5:00 PM].

Baum F. (1995). Researching Public Health: Behind the Qualitative-Quantitative Methodological Debate. *Social Science and Medicine*, 40: 459-468.

Baum F. (2007). Cracking the nut of health equity: top down and bottom up pressure for action on the social determinants of health. *IUHPE – Promotion & Education,* 14 (2): 90-95. [Online], Available: www.bvsde.paho.org/bvsacd/cd66/FranBaum.pdf [Downloaded: March 8, 2011 1:46 PM].

Becker J., Kovach A. C., and Gronseth D. L. (2004). Individual Empowerment: How Community Health Workers Operationalize Self-Determination, Self-Sufficiency, And Decision-Making Abilities Of Low-Income Mothers. *Journal Of Community Psychology*, 32(3): 327–342.

Bender D. E. and Pitkin K. (1987). Bridging the Gap: The Village Health Worker as the Cornerstone of the Primary Health Care Model. *Social Science Medicine*, 24 (6): 515-528.

Commission on Social Determinants of Health (CSDH). (2007). A Conceptual Framework for Action on the Social Determinants of Health: Discussion paper for the Commission on Social Determinants of Health. [Online], Available: www.who.int/social_determinants/.../csdh_framework_action_05_07.pdf [Downloaded: March 22, 2011 3:00 PM].

Commission on Social Determinants of Health (CSDH). (2008). *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health*. Geneva: World Health Organisation.

Coreil J. (1995). Group Interview Methods in Community Health Research. Medical Anthropology, 16:193-210.

Dasgupta K. (2012). The mothering effect. *Hindustan Times*. [Online], Available: http://www.hindustantimes.com/News-Feed/TopStories/The-mothering-effect/Article1-830744.aspx [Downloaded: April 27, 2012 8:32 PM].

Deaton A. and Dreze J. (2002). Poverty and Inequality in India: a Re-examination. *Economic and Political Weekly*, 37 (36): 3729-3748.

Dhote Y. (2009). Hum mey hai dum, Mitanin hain hum. *Outlook Magazine*: 29.

European Union State Partnership Programme (EUSPP). (2011). “Draft Report on Evaluation of the Community Health Volunteer (Mitanin) Programme”. Raipur: Department of Health, Chhattisgarh. [Online], Available: http://health.cg.gov.in/ehealth/MitaninFinalReport11thMarch2011.pdf

[Downloaded: January 4, 2012 5:45 PM].

Farquhar S. A., Michael Y. L. and Wiggins N. (2005). Building on Leadership and Social Capital to Create Change in 2 Urban Communities. *American Journal of Public Health,* 95: 596-601. [Online], Available: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449226/?tool=pubmed

[Downloaded: March 8, 2011 2:31 PM].

Forest Survey of India (FSI). (2011). India State of Forest Report, 2011. Dehradun: Ministry of Environment & Forests. [Online], Available: http://www.fsi.org.in/cover_2011/chattisgarh.pdf

[Downloaded: May 20, 2012 2:51 PM].

Freire P. (1996). Pedagogy of the Oppressed. London: Penguin Books.

Gifford S. (1996). Qualitative Research: The Soft Option? *Health Promotion Journal of Australia*, 6: 58-61.

Giffford S. (Undated). Unit 86- Analysis of Non-numerical Research. In Kerr C., Taylor R., and Heard G. *Handbook of Public Health Methods*. Sydney: McGraw Hill: 543-554.

Green J. and Britten N. (1998). Qualitative Research and Evidence Based Medicine. *British Medical Journal*, 316:1230-1232.

Green J. and Thorogood N. (2004). Ch-2 Developing Qualitative Research Designs. In *Qualitative Methods for Health Research*. London: Sage Publications: 27-50.

Ingram M., Sabo S., Rothers J., Wennerstrom A., Guernsey de Zapien J. (2008). Community Health Workers and Community Advocacy: Addressing Health Disparities. *Journal of Community Health*, 33:417–424.

International Institute for Population Sciences (IIPS). (2010). District level Household and Facility Survey (DLHS-3) 2007-08. Mumbai: IIPS.

International Institute for Population Sciences (IIPS) and Macro International. (2007). National Family Health Survey (NFHS-3) 2005–06: India: Volume I. Mumbai: IIPS.

Joe W., Mishra U. S. and Navaneetham K. (2008). Health Inequality in India: Evidence from NFHS. *Economic and Political Weekly,* 43 (31): 41-48.

Keen J. and Packwood T. (1995). Case study evaluation. *British Medical Journal*, 311:444-446.

Krishnamurthy M. and Zaidi S. (2005). Community Health Worker Programmes: Essential Elements and Enabling Environments. Social Initiatives Group, ICICI Bank. [Online], Available: http://www.icicifoundation.org/media/publication/Community_Health_Worker_Progs_essential_elements_enabling_environments.pdf [Downloaded: February 24, 2011 4:12 PM].

Labonte R. (2010). Health Systems Governance for Health Equity: Critical Reflections. *Rev. salud pública,* 12 (1): 62-76. [Online], Available: www.scielosp.org/pdf/rsap/v12s1/v12s1a05.pdf [Downloaded: February 24, 2011 6:58 PM].

Lawn, J. E., Rohde, J., Rifkin, S., Were, M., Paul, V. K., Chopra, M. (2008). Alma Ata: Rebirth and Revision 1. 30 Years On: Revolutionary, Relevant, and Time to Revitalize. *The Lancet*, 372 (9642): 917-927.

Lehmann U., Friedman I., and Sanders D. (2004). Review of the Utilisation and Effectiveness of Community-Based Health Workers in Africa

Lehmann U. and Sanders D. (2007). Community health workers: What do we know about them? Geneva: World Health Organization (WHO).

Loewenson R. (2009). Social empowerment as a determinant of health. [Online], Available:http://healthexchangenews.com/2009/06/16/social-empowerment-as-a-determinant-of-health-2/ [Downloaded: March 22, 2011 3:00 PM].

Malterud K. (2001). Qualitative Research: Standards, Challenges and Guidelines. *The Lancet*, 358: 483-488.

Morgan M., Spicer J., Reid M. (2002). Ch 7.1- Sociological and psychological investigations. In Detels R., McEwen J., Beaglehole R., Tanaka H. (eds). *Oxford Textbook of Public Health.* New York: Oxford University Press.

Nandi S. (2005). Right to Health Action by Mitanins in Koriya District. Medico Friend Circle Bulletin, 311: 18-23. [Online], Available: http://www.mfcindia.org/mfcpdfs/MFC311.pdf [Downloaded: August 12, 2010 4:07 PM].

National Rural Health Mission (NRHM). (2005a). Framework for Implementation 2005-12. [Online], Available:http://mohfw.nic.in/NRHM/Documents/NRHM_Framework_Latest.pdf [Downloaded: August 8, 2010 4:00 PM].

National Rural Health Mission (NRHM). (2005b). Guidelines on Accredited Social Health Activists (ASHA). [Online], Available: www.mohfw.nic.in/NRHM/RCH/guidelines/ASHA_guidelines.pdf [Downloaded: April 9, 2011 5:13 PM].

National Rural Health Mission (NRHM) Chhattisgarh. (2011). NRHM Programme Implementation Plan, Chhattisgarh 2011-12: Part B (Flexipool). [Online], Available: http://pipnrhm-

mohfw.nic.in/index_files/high_focus_non_ne/Chhattisgarh/Part_B(NRHM%20Flexipool).pdf [Downloaded: February 4, 2012 5:30 PM].

National Health Systems Research Center (NHSRC). (2010). ASHA: Which way forward. Evaluation of the ASHA Programme. [Online], Available: http://nhsrcindia.org/download.php?downloadname=pdf_files/resources_thematic/Community_Participation/NHSRC_Contribution/360.pdf [Downloaded: April 9, 2011 5:13 PM].

Office of the Registrar General and Census Commissioner. (2001). Chattisgarh Census 2001. *New Delhi:* Government of India. [Online], Available: http://censusindia.gov.in/ [Downloaded: October 23, 2011 8:02 PM].

Office of the Registrar General and Census Commissioner. (2011). Provisional Population Totals: Chhattisgarh, *CENSUS OF INDIA 2011. New Delhi*: Government of India. [Online], Available: http://censusindia.gov.in/ [Downloaded: November 18, 2011 4:17 PM].

Pawson R. and Tilley N. (2004). Realist Evaluation.

Pérez L. M. and Martinez J. (2008). Community Health Workers: Social Justice and Policy Advocates for Community Health and Well-Being. *American Journal of Public Health,* 98 (1): 11-14. [Online], Available: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2156047/?tool=pubmed [Downloaded: February 24, 2011 4:53 PM].

PHM-India. (2005). Report of the WHO regional consultation on Commission on Social Determinants of Health held on 15th and 16th of September 2005. WHO/SEARO, New Delhi. [Online], Available: http://phm-

india.org/index.php?option=com_docman&task=cat_view&gid=38&Itemid=15 [Downloaded: March 22, 2011 2:56 PM].

Planning Commission, Government of India. (2009). Report of the Expert Group to Review the Methodology for Estimation of Poverty. [Online], Available: http://planningcommission.nic.in/reports/genrep/rep_pov.pdf [Downloaded: May 20, 2012 3:25 PM].

Prasad, B.M. and Muraleedharan V.R. (2007). Community Health Workers: a review of concepts, practice and policy concerns. International Consortium for Research on Equitable Health Systems, Department for International Development and London School of Hygiene and Tropical Medicine, Chennai.

Public Health Resource Network (PHRN). (2010). Tribal Health. Book 15, New Delhi: PHRN.

Rajshekhar M. (2010). Patient Revolution. *The Economic Times*. June 1 2010 [Online], Available: http://articles.economictimes.indiatimes.com/2010-06-01/news/28397385_1_health-centre-bastar-chhattisgarh [Downloaded: April 9, 2011 4:25 PM].

Ramalingaswami V., Jonsson U and Rohde J. (1996). Commentary: The Asian Enigma. In *The progress of nations 1996*. New York: United Nations Children's Fund.

Rao M. (2009). 'Health for All' and neoliberal gobalisation: and Indian rope trick. In Panitch L. and Leys C. (eds). Socialist Register 2010: Morbid Symptoms: Health under Capitalism. New Delhi: LeftWord Books.

Rice P. L., and Ezzy D. (1999). Sampling Strategies for Qualitative Research. In *Qualitative Research methods- A Health Focus.* Sydney: Oxford University Press: 40-50.

Robson C. (1993). Ch 9- Interviews and Questionnaires. In Robson C. *Real World Research*. Blackwell: 227-243.

Registrar General, India. (2002). *Sample Registration System (SRS) Bulletin*, 36 (1). New Delhi: Office of the Registrar General, GoI. [Online], Available: http://censusindia.net [Downloaded: May 2, 2012 9:40 PM].

Registrar General, India. (2011). *Sample Registration System (SRS) Bulletin*, 46 (1). New Delhi: Office of the Registrar General, GoI. [Online], Available: http://censusindia.net Downloaded: May 2, 2012 9:45 PM]

Sanders D. (1990). Equity in Health: Zimbabwe Nine Years On. *Journal of Social Development in Africa*, 5(1): 5-22. [Online], Available: http://archive.lib.msu.edu/DMC/African%20Journals/pdfs/social%20development/vol5no1/jsda005001002.pdf [Downloaded: April 2, 2011 7:31 PM].

Sanders D. (2008). Revitalisation of Primary Health Care and Health System Development: The Potential of Community Health Workers. *Presentation at International Symposium to commemorate the 30th anniversary of the Alma Ata Declaration at the London School of Hygiene and Tropical Medicine*. http://www.lshtm.ac.uk/events/particulars/2008/sept/4-Sanders.pdf.

Schaay N, Sanders D. (2008). International Perspective on Primary Health Care Over the Past 30 Years. In: Barron P, Roma-Reardon J, editors. South African Health

Review 2008. Durban: Health Systems Trust; 2008. URL: http://www.hst.org.za/publications/841.

Schulz A. J., Parker E. A., Israel B. A., Allen A., Decarlo M., and Lockett M. (2002). Addressing Social Determinants of Health Through Community-Based Participatory Research: The East Side Village Health Worker Partnership. *Health Education & Behavior*, 29 (3): 326-341. [Online], Available: https://depts.washington.edu/ccph/pdf_files/CEI-6.pdf [Downloaded: February 25, 2011 2:07 PM].

Sen G., Iyer A., and George A. (2002). Structural Reforms and Health Equity: A Comparison of NSS Surveys, 1986-87 and 1995-96. *Economic and Political Weekly,* 37, (14): 1342-1352.

State Health Society, Chhattisgarh. (2012). Minutes of the State Health Society Governing Board Meeting held on 17th April 2012. Raipur: Ministry of Health and Family Welfare, Chhattisgarh.

State Health Resource Center (SHRC). (2003a). Mitanin Programme: Conceptual Issues and Operational Guidelines. Raipur: State Health Resource Center. [Online], Available:http://www.shsrc.org/pdf/MitaninProgrammeConceptualIssuesandOperatio nalGuidelin.pdf.

State Health Resource Center (SHRC). (2003b). *Hamarey Bachhey Unki Sehat: Shishu Evum Bal Swasthya Se Jurey Vibhinna Muddein*, Mitanin Module-3. Raipur: State Health Resource Center.

State Health Resource Center (SHRC). (2003c). *Mitanin Tor Mor Goth: Mahila Swasthya Ke Vibhinna Ayam*, Mitanin Module- 4. Raipur: State Health Resource Center.

State Health Resource Center (SHRC). (2006). *Poshan Sehat Samajik Suraksha,* Mitanin Module. Raipur: State Health Resource Center.

State Health Resource Center (SHRC). (2010). Annual Report 2009-10. Raipur: State Health Resource Center.

State Health Resource Center (SHRC). (2011). State level MIS Report of the Mitanin Programme: January-July 2011.

Spencer M. S., Gunter, K. E., Palmisano G. (2010). Community Health Workers and Their Value to Social Work. *Social Work*, 55 (2).

Sundararaman T. (2007). Community health-workers: scaling up programmes. *The Lancet*. 369: 2058-2059.

Szreter S. (2008). The WHO and the Social Determinants of Health: Assessing theory, policy and practice. Presentation at the The Wellcome Institute for the History of Medicine 26th-28th November 2008. [Online], Available: https://www.ucl.ac.uk/.../social_determinants/whosocdeterminantspaperf.pdf [Downloaded: March 2, 2011 4:10 PM].

van Ginneken N., Lewina S. and Berridged V. (2010). The emergence of community health worker programmes in the late apartheid era in South Africa: An historical analysis. *Social Science Medicine*, 71(6-3): 1110–1118. [Online], Available: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2941026/?tool=pubmed [Downloaded: February 24, 2011 4:00 PM].

Varkevisser C. M., Pathmanathan I. and Brownlee A. (2003). Designing and Conducting Health Systems Research Projects, Volume 1: Proposal Development and Fieldwork. Amsterdam: KIT Publishers/WHO/International Development Research Center (IDRC).

Wallerstein N. (2006). What is the evidence on effectiveness of empowerment to improve health? *Health Evidence Network Report.* Copenhagen:WHO Regional Office for Europe. [Online], Available: http://www.euro.who.int/Document/E88086.pdf [Downloaded: April 2, 2011 4:45 PM].

Walsh, J., & Warren, K. (1979). Selective PHC- An Interim Strategy for Disease Control in Developing Countries. *The New England Journal of Medicine*, 30 (18): 967-974.

Werner D. (1977). The Village Health Worker: Lackey or Liberator. Prepared for: International Hospital Federation Congress Sessions on Health Auxiliaries and the Health Team Tokyo, Japan 22 - 27 May.

Werner, D. and Sanders, D. (1997). *Questioning the Solution: The Politics of Primary Health Care and Child Survival*, Palo Alto, California: HealthWrights: 75-86.

WHO. (2008). *The World Health Report 2008: Primary Health Care: Now More than Ever*. Geneva: World Health Organisation.

Yin R. (2009). Case Study Research: Design and Methods. Thousand Oaks, CA: Sage.

Appendix-1

UNIVERSITY OF THE WESTERN CAPE

School of Public Health

Private Bag X17 ● **BELLVILLE** ● 7535 ● South Africa

Tel: 021- 959 2809, Fax: 021- 959 2872

PARTICIPANT INFORMATION SHEET

Role of Community Health Workers (CHWs) in addressing social determinants of health

Dear…………………………..

My name is Sulakshana Nandi. I am a student of Masters in Public Health at the University of Western Cape, South Africa. As part of my course, I am required to undertake a research study. I am focusing on the role of Community Health Workers (CHWs) in addressing social determinants of health. As you have been involved in this work, I would like you to participate and hear your views and experiences.

Why are we doing this?

I am conducting a study on the role of Community Health Workers (CHWs) in addressing social determinants of health in Chhattisgarh. This will help us to identify the challenges and facilitating factors in such actions and accordingly give recommendations for the existing or future CHW programmes.

Who are the participants?

The respondents include CHWs (Mitanins) and people who have been involved with those CHWs in addressing certain social determinants in Chhattisgarh.

What do we expect from the participants?

For this I would like to ask you questions about the action on social determinants, how and why it started and about everything that happened, including the outcome of the action. It will take around 30 minutes to an hour. If you agree to participate, your identity will be kept anonymous and confidential, but the information you share may be used in the study and any further publications. I will refer to you by pseudonym or invented name, which you could choose now.

During the course of discussions, certain issues may be touched upon, which you may not prefer to discuss. I will not be offended and there will be no negative consequences if you would prefer not to answer a question.

What can the participants expect?

After completing the study, the findings will be shared with the State Health Resource Center (SHRC), which is facilitating the Mitanin programme and other working on CHWs. The learnings from your experiences will add to the understanding on CHWs addressing social determinants on health so that similar work can be replicated in other CHW programmes.

Can you withdraw from the study?

Participation in this survey is voluntary you can choose not to answer any individual question or all of the questions. However, we hope that you will participate in this study since your views are important.

At this time do you want to ask me any questions?

My contact phone number is 9406090595. More information may be obtained from Prof. Helen Schneider who is contactable at hschneider@uwc.ac.za or Mr. J.P. Mishra, Executive Director of the State Health Resource Center, Raipur, who is contactable at 0771-2236175.

If you are willing to participate in the study please read and sign the consent form/give verbal consent.

Appendix- 2

RECORD OF INFORMED CONSENT TO PARTICIPATE IN INDIVIDUAL INTERVIEW

Title of study: Role of Community Health Workers (CHWs) in addressing social determinants of health

Date:

Interviewer: Sulakshana Nandi

UWC Student no: 3011277

Tel: 9409090595

E-mail: sulakshana.nandi@gmail.com

Institution: University of the Western Cape (UWC)

Interviewee's pseudonym:

Place at which the interview was conducted:

Thank you for agreeing to participate in an in-depth Interview. What follows is an explanation of the purpose and process of this type of interview. You are asked to give your consent to me on tape when we meet to conduct the interview.

1. Information about the interviewer

I, Sulakshana Nandi am a student of Masters in Public Health at the University of Western Cape, South Africa. As part of my course, I am required to undertake a

research study. I am focusing on the role of Community Health Workers (CHWs) in addressing social determinants of health. As you have been involved in this work, I would like you to participate and hear your views and experiences. I am accountable to Prof. Helen Schneider who is contactable at hschneider@uwc.ac.za and Mr. J.P. Mishra at the State Health Resource Center, Raipur, who is contactable at 0771-2236175.

Here is some information to explain the purpose and usage of the interview.

2. Purpose and contents of interview

I am conducting a study on the role of Community Health Workers (CHWs) in addressing social determinants of health in Chhattisgarh. This will help us to identify the challenges and facilitating factors in such actions and accordingly give recommendations for the existing or future CHW programmes. The respondents include CHWs (Mitanins) and people who have been involved with those CHWs in addressing certain social determinants in Chhattisgarh.

3. The interview process

For this I would like to ask you questions about the action on social determinants, how and why it started and about everything that happened, including the outcome of the action. It will take around 30 minutes to an hour.

4. Anonymity and confidentiality of contributors

If you agree to participate, your identity will be kept anonymous and confidential, but the information you share may be used in the study and any further publications. At all times, I will keep the source of the information confidential and refer to you or your words by a pseudonym or invented name, which I would like you to choose. I shall

keep any other records of your participation locked away at all times, and destroy them after the data has been collected and analysed.

5. Things that may affect your willingness to participate

During the course of discussions, certain issues may be touched upon, which you may not prefer to discuss. I will not be offended and there will be no negative consequences if you would prefer not to answer a question. I would appreciate your guidance should I ask anything which you see as intrusive.

6. Agreement

6.1 Participant's agreement

I, the respondent have been informed about the purpose of the study and what my participation involves. I also understand that I can withdraw from the study at any time, without having to give a reason and that the study is completely voluntary. I also understand that confidentiality will be maintained and that the findings of the study will only be used for research purposes.

6.2 Interviewer's agreement

I, the interviewer shall keep the contents of the above research interview confidential in the sense that a pseudonym will be used in all documents to refer to the respondent. The contents will be used for the purpose as referred above and may be used for published or unpublished research at a later stage without further consent. Any change from this agreement will be renegotiated with you.

Signed by interviewer: **Date:** **Place:**

Signed by participant: **Date:** **Place:**

Appendix- 3

RECORD OF INFORMED CONSENT TO PARTICIPATE IN GROUP INTERVIEW AND CONFIDENTIALITY BINDING FORM

Title of study: Role of Community Health Workers (CHWs) in addressing social determinants of health

Date:

Interviewer: Sulakshana Nandi

UWC Student no: 3011277

Tel: 9409090595

E-mail: sulakshana.nandi@gmail.com

Institution: University of the Western Cape (UWC)

Interviewee's pseudonym:

Place at which the interview was conducted:

Thank you for agreeing to participate in a group interview. What follows is an explanation of the purpose and process of this type of group interview. You are asked to give your consent to me on tape when we meet to conduct the group interview.

1. Information about the interviewer

I, Sulakshana Nandi am a student of Masters in Public Health at the University of Western Cape, South Africa. As part of my course, I am required to undertake a

research study. I am focusing on the role of Community Health Workers (CHWs) in addressing social determinants of health. As you have been involved in this work, I would like you to participate and hear your views and experiences. I am accountable to Prof. Helen Schneider who is contactable at hschneider@uwc.ac.za and Mr. J.P. Mishra at the State Health Resource Center, Raipur, who is contactable at 0771-2236175.

Here is some information to explain the purpose and usage of the group interview.

2. Purpose and contents of interview

I am conducting a study on the role of Community Health Workers (CHWs) in addressing social determinants of health in Chhattisgarh. A group discussion is a kind of group interview. It will assist me to explore your experiences in action on social determinants and the role of the CHWs, including the challenges and facilitating factors and accordingly give recommendations for the existing or future CHW programmes.

3. The interview process

I ask questions to start and guide a discussion among the participants and at times will probe further based on the responses of participants in order to facilitate a wider discussion. At times I may encourage more quiet participants to share their views but at no time will anyone be forced to say anything. All participants are asked to participate freely while respecting the views of other participants. We will start by completing the basic demographic information about participants. The group discussion will be recorded.

4. Anonymity and confidentiality of contributors

Protecting the anonymity and confidentiality of all participants, including yours, is of utmost importance. By agreeing to participate in this discussion, you also agree to keep the identities of all participants confidential, and to avoid divulging or discussing their identities or anything that was said by participants outside of this discussion.

At all times, I will keep the source of the information confidential and refer to you or your words by a pseudonym or invented name, which I would like you to choose. I shall keep any other records of your participation locked away at all times, and destroy them after the data has been collected and analysed.

5. Things that may affect your willingness to participate

The discussion may touch on issues that may be sensitive or affect you emotionally. If there is anything that you would prefer not to discuss, please feel free to say so. I will not be offended and there will be no negative consequences if you would prefer not to answer a question. I would appreciate your guidance should I or other participants ask anything which you see as intrusive.

6. Agreement

6.1 Participant's agreement

I, the interview participant, indicate my consent to participate by signing below. I understand that consent to participate in the Group Interview also means that I promise not to divulge the identity of any of the participants, or to divulge or disclose anything that was said by participants during the discussion outside of this Group Interview.

6.2 Interviewer's agreement

I shall keep the contents of the above research interview confidential in the sense that the pseudonym noted above will be used in all documents which refer to the interview. The contents will be used for the purposes referred to above, but may be used for published or unpublished research at a later stage without further consent. Any change from this agreement will be renegotiated with you.

Signed by interviewer: **Date:** **Place:**

Signed by participant: **Date:** **Place:**

Appendix-4

Interview Guide: CHW Interview

Date of Interview …………… Interview Starting Time: ……………….

Block: ……… District …………Village: …… Name of CHW's hamlet: …………

Socio- Demographic information

- Name/Pseudonym
- Age
- Educational Status
- Caste / Tribe
- Religion
- Marital status
- Economic status- Monthly income, main occupation

Experience as CHW

- CHW since when
- Hamlet and population/community seen by her
- Selection procedure
- Rounds of trainings attended
- Nature of work she does
- Role she perceives for herself

Experience in addressing social determinants of health

- Process of identifying the issues for taking action
- Nature of actions taken

- Participation of the community
- Impact on social determinant
- Challenges faced
- Facilitating factors
- Future actions planned
- Future support needed

Appendix-5

Community Group Interview Guide

- Social and demographic profile of the participants
- Experience with CHW of their hamlet/village
- Perceived role of CHW
- Group's participation in addressing social determinants of health
- Process of identifying the social determinant
- Nature of actions taken
- Impact on social determinant
- Challenges faced
- Facilitating factors
- Future actions planned

Appendix- 6

Training Rounds in the Mitanin Programme

Rounds	No. of days	Topic
2003-2006		
Round 1	4	Social determinants of Health, Introduction to the Mitanin Programme, Healthcare services and entitlements, Preventive and Promotive Child Health
Round 2	2	Refresher of Round 1- more pictorial
Round 3	3	Gender and Health, Maternal health
Round 4	2	Malaria (including community planning to fight malaria) and Gastroenteritis
Round 5	4	Mitanin Drug kit and first contact curative care
Round 6	2	National Tuberculosis Control Programme and National Leprosy Eradication Programme
Round 7	2	Panchayats and Health
2006-2009		
Round 8	2	Food Security and Social Security, addressing social exclusion
Round 9	2	Herbal remedies
Round 10	8	Neonatal Survival – Counseling, Screening, Referral
Round 11	2	Village Health Sanitation Committees and Village Health Planning
Round 12	2	Infant and Young Child Feeding

2009-2010		
Round 13	4	Behaviour Change Communication- Kit with flip charts, playing cards with nutrition and health messages
2010-2012		
Round 14	2	Refresher- Malaria, Leprosy, TB + HIV-AIDS, Blindness Control and new Insurance scheme
Round 15	3	Neonatal care, screening and referral for neonatal Sepsis
Round 16 (ongoing)	6	Gender and Health and Maternal Health-Refresher + new schemes, laws and programmes for women
Bridge Training	6	For 6000 new Mitanins
Planned for 2012		
Round 17		Refresher on essential life saving skills (neonates)