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Enabling Social Accountability: The Community Health Worker Programmes of Chhattisgarh and Jharkhand

Arshima

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ABSTRACT

The Mitanin and Sahiyya community health worker programmes of Chhattisgarh and Jharkhand respectively, were initiated by civil society and state actors in the early 2000s. Employing mainly women, they were precursors to the Accredited Social Health Activist (ASHA) programme, launched across rural India in 2005.

Over the years, efforts were made by civil society participants to bring about a wider rights-based focus to the Mitanin and Sahiyya programmes. In the case of Chhattisgarh, Mitanin women have engaged in rights-based action concerning a range of health and social issues, including nutrition, sanitation, education, pensions, forest rights, land acquisition, legal justice, gender-based violence, and caste discrimination. Thousands of Mitanin women have also become Panchayat representatives in Chhattisgarh. In contrast, the entry of Sahiyyas into Panchayat leadership positions in Jharkhand has been less frequent, while rights-based activities led by Sahiyyas are relatively rare.

This Policy Report explores the reasons why rights-based action has become part of the institutional design of the two programmes to differing degrees. The study details some of the contextual and organisational factors enabling individual and collective action for social accountability.

While the origins of civil society engagement and wider culture of governance may not be easily amenable to change, the Report recommends ways in which the Sahiyya and ASHA organisations may be structured differently, in order to enhance activism by workers. One of these strategies entails the promotion of a leadership cadre 'from below', in which frontline workers are permitted to rise to leadership positions at cluster, block, district and (eventually) State-level. Allowing these leaders to subsequently carry out both training and monitoring roles would further encourage bottom-up planning and collective problem-solving. The creation of multiple platforms of group interaction between successive programme levels is also essential to enable the two-way exchange of information based on grounded experience, necessary for building both local and state capacity. Without such organisational changes, community forums involving ASHAs such as village health committees are likely to remain dysfunctional.

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I. Introduction

Chhattisgarh and Jharkhand were carved out of Madhya Pradesh and Bihar in the year 2000. In the same year, quite independently, efforts began in both States to initiate programmes for community health workers, in which thousands of women living in villages would be trained to meet the health needs of their communities. In both States, civil society members engaged with the government to design and implement large-scale community health worker (CHW) programmes. However, the differing trajectories of the two programmes, as well as the distinct state and civil society contexts in which they were initiated, have had different consequences for the kinds of activities initiated by CHWs and their leadership.

Both the Mitanins[1] of Chhattisgarh and the Sahiyyas[1] of Jharkhand are women, and act as referral agents for the state health system, taking women for deliveries to hospitals, referring patients with

1. 'Mitanin', the name given to the community health worker, means 'close friend' in Chhattisgarhi. Although chosen independently, the name 'Sahiyya' alsomeans 'friend' in a local dialect in Jharkhand.

specific diseases for treatment, offering counselling on maternal and child health, and giving basic medication to villagers. Attempts were made by civil society leaders in Chhattisgarh and Jharkhand to broaden the scope of activities of Mitanins and Sahiyyas. In both States, many such female CHWs have gone on to fight elections in Panchayati Raj Institutions (PRIs), often becoming more effective Panchayat leaders than their female PRI counterparts. In both States, public hearings involving community-based monitoring (CBM) are also organised at the block-level, providing community health workers and (potentially) villagers with an opportunity to make their demands heard by State representatives.

Although notable when compared with the ASHA programme in most other States in India, efforts to engage Jharkhand's Sahiyyas in PRIs and CBMs have been limited as compared with the equivalent strategies in Chhattisgarh. While 3,500 Mitanin programme workers have reportedly become Gram Panchayat leaders across Chhattisgarh (of the 54,000 positions reserved for women), data collected by the Sahiyya programme suggests that only 335 Sahiyyas were PRI representatives between 2011 and 2015. Attempts to engage Sahiyyas on other rights-based activities

have also been sporadic, with the organisation of such activities usually left to the initiative of individual programme leaders or to the agency of Sahiyyas themselves. As a result, rights-based action by Sahiyyas is less frequently visible, and appears to occur more routinely on issues directly related to Sahiyya needs, and less often on the needs of villagers, such as the demand for improvements in local medical or social services.

In contrast, the Mitanins of Chhattisgarh and their (majority female) leadership from block to district-level are trained to work on a number of health and social rights, strengthening government programmes for nutrition, livelihoods, education and health, working with villagers to prevent domestic violence and alcoholism, and in a few districts initiating campaigns for land and forest rights against powerful corporations and corrupt officials. In many cases, these activities are systematically promoted or organised by the Mitanin programme's State-level leadership; on occasions, efforts arising spontaneously at the village-level are provided with support from above.

Photo: Arshima

Picture 1: Mitanin programme workers leading a tribal community meeting against land acquisition in Chhattisgarh.

This study explores the reasons underlying the different activities visible in the Mitanin and Sahiyya programmes, by examining the enabling and constraining factors for social accountability at village, block, district and State-level. This Report first discusses the policy rationale underlying the development of community health worker programmes, and describes the differing roles of CHWs conceptualised in India and elsewhere. The research methodology is summarised, followed by the study findings on the origins of the two programmes, the different types of CHW activities identified, and the various institutional factors underlying these differences between the two States.

II. Improving Health in Rural India

Although policy makers in India supported the notion of "health for all" since independence (Bhore Committee, 1946), the health services inherited in 1947 were concentrated in cities (Duggal, 2001; Jeffery, 1988), despite the reality that 83 per cent of the population lived in rural areas (Census, 1951). During the last 65 years, economic and social opportunities have expanded considerably in urban India, leaving villages grossly under-served. Poor health indicators are attributed to an increasingly unequal pattern of growth adopted by the state that has unfolded through market forces over the decades (Ghosh, 2011). Meanwhile, Union and State spending on health in India has grown sluggishly. Public expenditure on health increased incrementally from 0.93 per cent of the Gross Domestic Product (GDP) in 2007-8 to 1.04 per cent in 2011-12 (GoI 2012, p.3),[2] and remains one of the lowest figures for investment in health globally.

[2] GoI. (2012). Report of the Working Group on National Rural Health Mission (NRHM) for the Twelfth Five Year Plan (2012-2017). New Delhi: Planning Commission, Government of India.

The health system also suffers from an inability to absorb increases in allocation, with some State governments returning funds to the centre (Sen, 2011). Funding limitations in health contribute to large vacancies of health service providers, delays in payments leading to demoralisation, and to providers choosing to serve better connected areas, often belonging to upper caste and politically connected sections of society (Roy, 2007). Medical personnel who do work in rural India tend to choose villages with better housing, schools for children and employment for spouses (Sheikh et al., 2012), suggesting that continued reliance on highly qualified professionals is likely to condemn economically deprived and underdeveloped areas to poor healthcare.

In these circumstances, several low and middle-income countries have developed CHW programmes with the aim of training a cadre of health personnel rooted in the local village community. The Global Health Workforce Alliance, created in 2006 to address health worker shortages in developing countries, calls for the expansion of such training programmes to ensure that "all people everywhere shall have access to a skilled, motivated and supported health worker, within a robust health system," (WHO, 2012, p.4).

The Indian government had advocated the recruitment of villagers as health workers as early as 1943 (Bhore, 1946). Yet, only from the 1960s onwards did the work of China's barefoot doctors and several NGOs across India reveal the potential of village communities to improve their own health (NIHFW, 1978; Bhatia & Antia, 1993; Arole & Arole, 1994; R. Bang, 2010; NHSRC, 2011; Rifkin, 2014).

The Alma Ata declaration gave impetus to a growing international movement in which village health workers became a symbol of community participation (WHO, 1978). Local, global and academic efforts came to fuel the launch of several large-scale community health worker programmes in India, though some failed to perform (Desai, 1992; Ashtekar, 2001). Several State governments also initiated schemes for community health workers (Sundararaman, 2006), with the Mitanin programme being perhaps most prominent in these efforts (Nambiar, et al., 2012).

In 2005, the National Rural Health Mission (NRHM) was introduced to expand public spending and decentralise healthcare delivery to villages. The NRHM departs from the approaches of previous government health programmes in three significant ways.

First, it emphasises the engagement of local communities in programme implementation and monitoring. Second, it integrates a language of rights in its view of health. Third, it gives a substantial role to civil society organisations in the policy design, implementation and monitoring of health programmes (Unnithan and Heitmeyer, 2012). Described as "the most visible face of the NRHM," the ASHA scheme has been central to policy efforts to improve the health of the rural population (GoI 2011, p.36).

The stated aims of the ASHA programme are to train one community health worker per 1,000 village population in three main health-related activities: referral to health centres, healthcare provision, and activism on the social determinants of health. The Mitanin programme of Chhattisgarh and the Sahiyya scheme of Jharkhand, initiated prior to the national ASHA programme, have promoted these three roles among their CHWs to differing degrees. In both States, individual civil society and state actors had familiarity with the decades of NGO efforts in community health that suggested that training villagers to become health workers was not only possible, but a necessary bottom-up means of strengthening state health policies.

The Community Health Worker: Lackey or Liberator?

It is important to clarify what 'community health worker' means as the terminology used differs in the international arena and between different regions within India. CHWs can be referred to as community health volunteers, field health workers, health activists or using various local terms. This Report adopts the World Health Organisation (WHO) Study Group definition of CHWs as those who "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 organisation, and have shorter training than professional workers," (Lehmann and Sanders, 2007, p.3). As Haines et al (2007, p.2122) point out, however, "[i]n practice, precise classification can be difficult because of the wide range of backgrounds and roles of such health workers," and so some of these markers remain features only in principle.

Since their development in the mid-twentieth century, CHW schemes around the world have employed different strategies to improve population health. CHWs have most frequently taken on

the task of increasing awareness for health behavioural change in the community, improving access to public health services and acting as service providers of basic healthcare. These CHWs can be seen as an extension to existing state health systems. However, the role of CHWs as mere promoters or providers of curative care has been criticised—by civil society activists as well as academics—as diminishing their potential to act as agents of change tackling the social determinants of health.

In India, where health inequities have been shown to correlate significantly with poor nutrition, sanitation, water and education, as well as caste, class, gender and regional differences (Baru et al., 2010; Deaton and Drèze, 2009; Subramanian et al., 2006), the need to influence local socio-political factors in strategies to improve health has been seen as critical to the role of the CHW.

> "As anyone who has broken bread with villagers or slum-dwellers knows only too well: the health of the people is far more influenced by politics and power groups and by the distribution of land and wealth than it is by the treatment or prevention of disease… Thus the village health worker becomes an integral agent of change, not only for healthcare but for the awakening of his people to their human potential, and ultimately to their human rights" (Werner, 1981, p.49).

Thus the role of the CHW may be situated somewhere along a spectrum between two ideas: one that promotes curative care through increasing referral of patients to the health system as well as direct service provision by the CHW; and the other, that adopts an activist approach and seeks to change wider social determinants of health, reduce inefficiencies in the state system and alter the very structures of power that determine health inequalities. The two ends of the spectrum were termed famously by Werner (1981, p. 46) as "lackey or liberator", and are reflected in debates on health and participatory development programmes more generally.

Community Health Workers as Activists

Before investigating CHW mobilisation, it is important to categorise the varied forms that such activities can take. Bender and Pitkin (1987) in their work on CHWs in Costa Rica, Nicaragua, and Columbia, suggest that two activist roles can be conceptualised for the CHW. One is that of the 'revolutionary' CHW who mobilises communities in opposition to the state, challenging existing power structures; and the other, the 'social change' CHW who stimulates community work on social issues from within the government health system. The CHW

programmes that were formed in South Africa during apartheid belong to the former 'revolutionary' category. A study gathering oral histories of these programmes found that a desire for political change was at the basis of all endeavours, though different schemes adopted different approaches to the CHW role (van Ginneken et al., 2010). While in some programmes, CHWs take on more explicit forms of political activism, in others the CHWs seek social change and challenge power structures through the route of health service delivery.

The second category of 'social change' brought about through CHW activism is illustrated well in the example of the Kakamega Community-Based Health Care Project in Kenya, initially piloted by the state in 1976 and scaled up in 2006 through partnerships between communities, governments, and development organisations (Earth Institute, 2011, p.46-47). The programme institutionalised community engagement right from its inception. A Community Health Committee (CHC) was formed with representatives of women's groups, youth, and religious groups. CHWs were selected with public participation of the CHC. Monthly Community Dialogue Days were held with the community to discuss health concerns, and quarterly Community

Action Days involved mobilisation for social issues, such as the protection of water resources, inspection of latrines or fundraising for identified felt needs (issues perceived as important by the community). Information on CHW responsibilities was made public on a blackboard in the community centre and regular home visits were conducted by the CHW to further build trust with community members. The state thus induced a formal process of community participation in the programme.

In between the 'revolutionary' and 'social change' categories are those that demand accountability and justice from the state, but do not seek to change existing structures. In doing so, they remain outside of the state but reinforce rather than challenge the state's power to provide resources. Three CHW programmes in the U.S. are illustrative of such efforts. Farquhar et al. (2005), Ingram et al. (2008) and Pérez and Martinez (2008) describe the leadership roles of CHWs in the mobilisation of migrant, vulnerable, and minority communities around social issues. In these programmes, CHWs encouraged the formation of networks among the population through awareness and advocacy campaigns, demanding entitlements from the state on issues such as poverty, employment, housing and discrimination.

The current forms of activism visible in the Mitanin and Sahiyya programmes by and large entail efforts for 'social change' and 'accountability'. However, programme leaders in Chhattisgarh and Jharkhand saw both social change and accountability action as being prerequisites for revolutionary change. Long-term ideals were not considered separate from short-term achievements, but rather a larger vision was seen as the eventual aim of more incremental change.

As this Report will show, activities for social change can often lead to action for accountability. Similarly, when conceptualised as efforts that build the capabilities of villagers, both social change and accountability can be seen as stepping stones towards revolutionary change, even when by themselves they may appear less radical. What the differing developments of the Mitanin and Sahiyya programmes in fact highlight are important lessons for those seeking structural change at scale.

III. Research Method

Between July 2013 and August 2014, for my doctoral fieldwork, I had spent eight months conducting ethnographic research in five districts[3] of Chhattisgarh, investigating Mitanin programme efforts at the village, block, district, and State-level. The challenges that workers experienced in 38 different village-level health and social activities were identified, along with the factors that helped to overcome these challenges in successful episodes (see Arshima, 2017).

The data collected during my PhD was combined with fieldwork in Jharkhand, in which two months were spent between May and August 2016, conducting interviews, group discussions, and participant observation with Sahiyyas, mid-level and senior programme leaders, including State administrators and civil society activists (and those straddling both roles), who were either current or former participants in the programme. The districts visited included Ranchi, Gumla, Palamu, West Singhbhum, Godda,

3. Given the more contentious nature of activities led by some Mitanin workers, and in keeping with my doctoral thesis, the five districts are anonymised to avoid any harm coming to programme participants.

Hazaribagh and Bokaro. Due to the varied nature of activities ongoing in the programme within the short period of research, I was unable to attend the same meeting or event in each district, or interview similar cadres of workers across districts for comparison. Rather, I identified the most relevant activities being held in particular districts of Jharkhand during my field study, such as a CBM event in Angara block, Ranchi, and interviewed the most 'active' individuals participating in the event, such as the District Programme Coordinator, five Sahiyyas, two Auxiliary Nurse Midwives, and three officials in the Health Department.

A total of 39 in-depth interviews were carried out, along with many more informal conversations, identifying respondents' perspectives on the origins of the programme, its contested aims, its evolution, their personal role and involvement, the contextual and programmatic barriers to rights-based action, and the efforts needed to overcome these challenges. When interviewing Sahiyyas who had been involved in activities (of various kinds), life histories were gathered in order to identify enabling factors that may lie outside the programme itself. Efforts were made to interview Sahiyyas from a variety of caste, tribal, or religious backgrounds.

During the study, I came to realise that it was important to observe and interview women engaged in Self-Help Groups (SHGs) in Jharkhand, who had demonstrated success in mobilising for accountability as well as contesting in Panchayati Raj elections (perceived by civil society and state administrators as a relatively more 'revolutionary' activity), at a scale that seemed larger than the Sahiyyas, and was comparable to the Mitanins of Chhattisgarh. The data collected here is not discussed explicitly, but provided a crucial comparator to explore how women's capabilities could be developed for rights-based action, and to understand why Sahiyyas seemed comparably weaker. In Godda district, where I was able to participate in several meetings more closely, these women were supported by Pradan, a non-governmental organisation with prolonged field experience in developing women's leadership through SHGs. For similar reasons, interviews were also held with Sahiyya programme participants who had experience of working with the Jharkhand State Livelihood Promotion Society, promoting the development of SHG federations (which resembled the institutional structure of the Mitanin programme, but was quite different to the Sahiyya scheme, see pp. 43-53).

The data collected from my fieldwork in Chhattisgarh and Jharkhand was typed and coded manually on to Microsoft Word. The codes were ultimately grouped into the following categories, depicting the conditions that enable or constrain social accountability in the two states: embedding state-civil society engagement within the institution; civil society context; government culture; programme structure and leadership; accountability dynamics within the institution; and the nature of CHW activities themselves. The subsequent chapters discuss these factors in this order.

IV. Findings – Part One: Building Institutions for State-Civil Society Engagement

The contexts of Chhattisgarh and Jharkhand share many similarities. The two States are mineral-rich with large forest areas, and were both created in November 2000. The poverty rate in 2012 was 40 per cent in Chhattisgarh, and 37 per cent in Jharkhand. The population size of the two States is similar—28 million and 32 million, respectively. Both States have a substantial tribal presence, with one-third of the population being Scheduled Tribes (ST) in Chhattisgarh, and a quarter in Jharkhand. The infant mortality rate is slightly higher in the former State, at 46 per 1,000 live births, as compared with 37 in Jharkhand (Chhotray et al., 2016).

Yet, Chhattisgarh has promoted industrial growth and power generation more aggressively, and has been more successful in its reforms to the Public Distribution System (PDS), which provides subsidised food grain to the poor, having cut leakages by 82 per cent over a period of seven years as compared with 48 per cent in

Jharkhand. As Chhotray et al.'s (2016) comparative study of the political settlements in the two States confirms, Chhattisgarh has a better organised administrative workforce and a longstanding dominant political leader, while Jharkhand suffers from weaker state capacity and less bureaucratic autonomy. Even rent-seeking in Chhattisgarh is more organised with greater centralised control, while bureaucrats in Jharkhand seek to fulfil short-term interests via personal relationships with the political class (*ibid*). Many of these contextual differences are reflected in the distinct trajectories of state-civil society engagement visible in the Mitanin and Sahiyya programmes.

However, Jharkhand has a stronger civil society network, with a longer history of state-civil society negotiation. Among the handful of civil society members, programme workers, and government respondents I met who had worked in Chhattisgarh as well as Jharkhand, it was a widely held belief that the rural women of Jharkhand were much more capable of engaging in rights-based action than those of Chhattisgarh. This was attributed to higher levels of tribal and women's empowerment in the former State, due partly to the Chotanagpur Tenancy Act, 1908, and the Santhal Pargana Tenancy Act, 1949, which had long prevented tribal land

from being transferred to non-tribals. Jharkhand has a better organised network of rights-based NGOs across rural areas compared with Chhattisgarh, and the State was formed following prolonged demands by social movements (Tillin, 2013). The more widespread presence of Christian missionaries, enhancing education and social capital also among women, was another contributing factor. A historical connection with Bihar, notable for strong caste-based political mobilisation, was further felt by civil society respondents to have had an impact on the rights-based culture of Jharkhand.

All these factors resulted in a comparably more outspoken cadre of Sahiyya workers in several meetings and group discussions, often in sharp contrast to my experiences with Mitanins in Chhattisgarh. However, the evidence of stronger civil society agency in Jharkhand raises the question of why a more systematic and prolonged presence of civil society has not been visible in the Sahiyya programme, and an institution akin to that of Chhattisgarh has never been set up.

Chhattisgarh: Embedding Civil Society within the State

The fact that Chhattisgarh was a newly formed State meant that in the year 2000, only a handful of bureaucrats comprised the State's Department of Health and Family Welfare. This vacuum was a clear window of opportunity, providing impetus to the State Health Secretary, who was familiar with the literature on CHWs in various parts of India, to invite civil society activists with a background in health to lead efforts for strengthening the health system. Among the initiatives discussed at collaborative meetings between state and civil society actors was a large-scale programme that would be based on learnings from NGO and state CHW schemes across the country.

Initial consultations in Chhattisgarh led to a consensus that a CHW scheme would be unlikely to succeed unless "wide-ranging structural reforms were undertaken by the GoC [Government of Chhattisgarh] to change the existing laws, policies, programmes and institutions of the state health delivery system" (Patnaik, 2003, p. 36). Working on the supply-side as well as the demand-side of the health system thus became paramount.

At the outset, state and civil society engagement was made possible in Chhattisgarh in two ways. First, the Department of Health formed a State Advisory Committee (SAC) comprising NGO members, State officials and funding agencies. Binayak Sen was one of the main NGO representatives who wrote about these initial collaborations. Sen (2005, p. 15) asserts that despite assurance given to civil society that they would be free of government interference for at least a year, the SAC was "quickly marginalised in the decision making process, and in fact, [at the time of writing in mid-2005] SAC meetings have not been held at all for the last 12 months."

The second form of state-civil society engagement was more lasting, and involved the creation of the State Health Resource Centre (SHRC). The SHRC is a registered NGO in which mainly civil society actors have taken leadership roles at the State-level, bringing together a range of experiences in health activism, literacy campaigns, and social accountability into an innovative form of governance (SHRC, 2003; Mishra, 2006). The consultations of 2002 gave the SHRC the task of supporting the Mitanin programme and wider health sector reforms (N. Roy, 2006). The Chhattisgarh government signed a Memorandum of

Understanding (MoU) with ActionAid (the programme's initial source of funding, later in conjunction with the European Commission) on the running of the SHRC for its first three years. Following a review in 2005, a contract was made between the SHRC and the State Health Society. Nandi (2012, p. 119) confirms that the SHRC's autonomous positioning "contributed greatly to the way the programme has emerged and the roles that Mitanins have played with respect to both healthcare and social determinants." As she puts it, facilitation by the SHRC has been "the single most important factor in the success of [the] programme" (*ibid*).

Roy (2006) points out, however, that the SHRC's liminal position means that "its recommendations may not be followed by the government." Nandi (2012, p.119) admits that as the Mitanin programme expands, "it is a constant struggle for SHRC to try and institutionalise it within the community rather than the government." Sen (2005) was critical of the SHRC's role in shaping Mitanin work in the programme's early years, suggesting that as soon as initial hurdles of implementation were overcome, the SHRC began to give greater emphasis to performance indicators rather than social determinants. Bureaucratic forces

seemed to narrow down the scope of Mitanin work "under the aegis of an agency that considered itself to be a 'Para-statal body'" (Sen, 2005, p.16). As Sundararaman (2003, p.34) had foreseen early on in the history of the programme, "State-Civil Society Partnership is the bedrock on which this programme is erected. Its strength will decide whether the programme stands or sinks."

Fifteen years later, in spite of the SHRC's liminal positioning and largely because of it, the abilities of the Mitanin workforce to strengthen social action have in fact expanded over time. Moreover, the programme's adoption of a 'right to health' framing, where the understanding of 'health' is holistic, has allowed its workers to act on social accountability, while contributing to their continued relevance for the state. So far, the SHRC maintains the substantive presence of civil society within state architecture.

In Jharkhand, however, a similar institution embedding civil society within the state was never developed. This is in part attributable to the context from which the civil society actors had emerged, the distinctiveness of the government context in Jharkhand, and due to the particular combination of individuals involved.

Jharkhand: Working the State from the Outside

In the year 2000, the Child in Need Institute (CINI) in Jharkhand initiated a review paper to map out the history of community health workers (CHWs) in India (a paper that was never published). The paper sought to track the work of organisations across the country from the Rural Unit of Health and Social Affairs (RUHSA) in Tamil Nadu to the Comprehensive Rural Health Project (CRHP) of the Aroles in Maharashtra, with a view to build upon these learnings and initiate efforts in Jharkhand. A young professor was brought in from Johns Hopkins to conduct a trial of a CHW initiative in two blocks of Jharkhand, though because of its technical orientation, there were problems with the study design. Nevertheless, the Health Secretary of the Jharkhand government had been going to nearly every CHW meeting initiated by CINI and was impressed by the CHW concept. He set up a Steering Committee engaging state and civil society actors, insisting that the idea of the CHW had to be scaled up. Unlike Chhattisgarh, the focus of state-civil society discussions remained limited to the CHW scheme itself, hence supply-side issues never came under the remit of civil society action.

The Industrial Credit and Investment Corporation of India (ICICI) Bank, at that time headed by a pro-poor leader, became involved in funding discussions. Two individuals from ICICI became involved in hunting for civil society actors who would be willing to run an institution akin to the SHRC, though this never materialised.

Instead, civil society actors have continuously attempted to 'work the state' on an individual basis, or as a small and loose network of individuals, tweaking policy from outside formal government structures. Initially, this was in the form of individuals leading what became the CINI pilot of the CHW programme.

The Sahiyyas were first selected in 2005 in 34 blocks of 7 districts (Ranchi, Hazaribag, Jamtara, Dumka, East Singhbhum, Gumla and Saraikela-Kharsawan), and then scaled up gradually across Jharkhand. Initial training was provided by local NGOs, but more than half of these were found to be corrupt or inefficient (as was also the case in Chhattisgarh). The NGO trainers were replaced by individual block and district-level trainers dedicated to the programme (see programme structure in Chapter V, pp. 43-53). Leadership was later provided through a handful of civil society

actors attempting to guide the government's Community Mobilisation Cell of the Jharkhand Rural Health Mission Society.

The Civil Society Context

In contrast to Chhattisgarh where civil society activists were invited from other states and became fully focused on health system reforms, most of the activists who had engaged in the Sahiyya programme at the State-level were rooted in various forms of mobilisation relevant to the Jharkhand context. Some of them had grown up in Jharkhand, and the origins of their collaboration arose in the 1990s, centring on the issue of land.

As one respondent described, when he was in college, he had seen 20,000-1,00,000 people displaced in his district due to dam construction. Even now, families had received no compensation for their loss of land. Another civil society member had alone visited 3,000 villages by foot over four years during his youth, assisting communities to solve problems on a range of issues. As one of them put it, witnessing struggles against dams, mining and industry as they were growing up, "I realised that no one else is going to come forward and work [for people]." One respondent

had decided to commit his life to the people since the JP movement: "Such movements create a breeding ground. Some people move into this work independently, some need something like the Anna *andolan* to inspire them." Others had been influenced by friends or mentors: "My college friends had an inclination. Seeing the problems around us—we ourselves didn't realise when we became part of this work."

In a group discussion, three civil society members explained that due to the distancing of people from their land, and consequently their connection with forest and water resources, communities had now become "totally dependent on the government". The activists saw their own role as suboptimal, given that the people's main asset had been taken from them, and this suboptimal role entailed helping the poor to at least gain the basic right to survive from the government. These comprised the right to food through the Mid-Day Meal Scheme (MDMS), Integrated Child Development Scheme (ICDS) and Public Distribution System (PDS), and the right to basic livelihoods through the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA). As one can expect, health came slightly lower in their order of priority, as compared with food and employment. Health was also a much

more technical subject that was perceived to require prolonged study of medicine, while a strong grasp of health systems dynamics required time devoted for reading, visionary thought, as well as work experience within the system—all of which only few activists could be confident about.

Each government scheme for health and social welfare was considered inadequate by most Jharkhand activists, in both design and implementation. However, in the absence of united civil society effort towards an alternative model of development, they felt that strengthening current state schemes was a requirement of the time. "It is your constitutional responsibility [as the government], to keep people alive." As one respondent put it:

> "So far we have had critical engagement with the government, in a positive way. We don't worry if it gets votes for the government. Our approach is struggle and constructive engagement. We have regularly engaged with bureaucrats—there is acceptance of our work, there are some with a pro-people mindset, who support any good move for the people of Jharkhand. The space is yet to open for dialogue, but there are a few opportunities we can take up. I am a member of the state employment guarantee council, chaired by the Chief Minister."

One activist went further to suggest that initiatives like the RTI (Right to Information) and the Sahiyya scheme, which involved

more substantial empowerment of marginalised villagers, in the latter case women, were not ends in themselves, but part of the effort towards more revolutionary action:

> "We need to envision larger change, structural as well as spiritual. On the way there, if we do not address the basic needs of the people, there is something wrong. So we need to strengthen rights to basic welfare, which will involve building the capabilities of the people. These capabilities will act as ingredients in further efforts to bring about changes in class, caste, and gender. But we cannot stop there—we have to keep the larger spiritual change in mind, which is the end goal, and forms the basis of rights, the basis of social justice."

All activists expressed a strong desire to direct the accountability of Sahiyyas towards the people of the village—"We wanted to keep the essence, the essence would be towards the community"—but few emphasised the organisational changes through which downward accountability could be maintained (see Chapter V). Instead, piecemeal efforts were made to improve transparency:

> "We put up notices on the Sahiyya training board: If you do not get it [food, supplies, travel allowance etc.] please call us—giving the State Programme Manager's number, and the Director's number. The Director called us, must have received so many calls, saying 'Take my number off'! We wanted them to know they can escalate their complaints."

While the general desire to envision social change was palpable, civil society respondents expressed this as a change emanating from organisational culture rather than as a consequence of organisational structure. As one activist described:

> "The government will run the programme on its own terms. We wanted to maintain the essence of a campaign, of asking questions. In many areas there is a problem of co-optation. But I think overall we have managed to keep it different."

A district-level worker, instead, complained that "no coherent vision was thought through in the development of the programme." This could be attributed to differing views on the aims of a CHW programme held by different Jharkhand activists, and consequently scattered attention given to the organisational processes by which the programme would be rolled out. Most importantly, the context in Jharkhand was different from Chhattisgarh, where civil society leaders had entered the state from other parts of the country, and were devoting their full attention to the Mitanin programme via the institution of the SHRC.

Seeking Civil Society Leadership

Two members of the ICICI spent several months attempting to "build a fist", a civil society group that could lead the Sahiyya

programme with teamwork and commitment. As one of them put it, "I had complete freedom about how I wanted to figure out things." Yet, as she discovered, civil society in Jharkhand was engaged in work on multiple rights-based schemes, including health as one of many activities. For some, the main part of this work involved negotiations with higher level government officials rather than local grassroots action. Many of those involved at the grassroots were, in turn, less familiar with the systems perspectives required to lead a large-scale institution.

In contrast, one of the founders of the Mitanin programme, also a medical practitioner, was described as "extremely brilliant, extremely charismatic" by one respondent in Jharkhand. Another civil society leader in Chhattisgarh had a background of several years of grassroots work on social accountability, which was not the core strength of any of the activists directly involved in the Sahiyya programme. This particular civil society leader in Chhattisgarh is now credited for scaling up rights-based action through the selection of a block-level cadre of female activists leading the Mitanins, and via the strengthening of village health committees.

All of the key leaders in the Mitanin programme were also prolific readers, familiar with both government publications as well as academic works related to health and social accountability, a combination of skills that was relatively rare in Jharkhand. In addition, while all the leaders of Chhattisgarh emphasised 'independent thinking' as a critical quality for their job, this was a relatively uncommon trait emphasised by activists in Jharkhand:

> "What makes a good activist—there should be intention, intuition, a connection with the people, confidence in the people, and someone who wins their trust." (Jharkhand activist)

In addition, independent thinking was particularly emphasised by Mitanin programme leaders, to stress that the aims of outside agencies—whether donors, the government, academics, or powerful local actors—needed to be worked with or around in order to fulfil larger aims that meet the interests of the poor. In contrast, some civil society respondents in Jharkhand described a less critical approach to decision-making: "If there are academic ideas that even villagers approve of, then there is no chance of getting it wrong."

Skills and the prior commitment to other work were perhaps the main reasons why a devoted team could not be identified to lead

the Sahiyya programme. One female NGO worker in Jharkhand also suggested that Sahiyya activists were all rooted in a rights-based discourse, whereas "the rights language doesn't work so well in health. You can demand that a doctor treats you, but you can't demand that he treats you well. You can demand payment, but you can't force people to be nice or behave well." So long as Sahiyyas were primarily trained on medical problems, she believed, their ability to work on rights was bound to be limited, as compared with the social rights more often encountered in the Mitanin programme. There were, of course, several instances where Mitanin workers had demanded a change in behaviour of officials in the Health Department, resulting in the transfer of a Block Medical Officer on one occasion, and of a Chief Medical Officer on another. These were not directly changing the doctor-patient relationship, however, which was more vulnerable to abuse, and less amenable to change.

Engaging with Government

Efforts to engage other activists in Jharkhand failed also due to their resistance to work with what they saw as a government that had become increasingly corrupt since the State had been formed.

One woman activist who had been training community health workers for several years in remote areas had proposed a training module for Sahiyyas:

> "I approached the Jharkhand State Health Society. No one replied to that. What they agreed to do they didn't do… They squeezed the blood out of us… This government is getting more corrupt, they are now asking us for bribes which they never did 10 years ago… If this is their way of working, I'm not going to work with them. We thought they would see our [training centre] as a model centre, and think 'we can do it too'. Instead what they try and do is to spoil ours, there's that competitiveness."

Nevertheless, in the initial stages of developing the Sahiyya programme, the Health Secretary had been enthusiastic about the medical role of CHWs, and encouraged the involvement of CINI members in scaling up a state-wide initiative. As a civil society respondent put it:

> "The government loved the idea of community health workers. There was no money involved as payment, nearly free training, it's a catch for them. The Anganwadi workers have unionised—[but] this was nearly voluntary."

A bureaucrat also explained that in the bureaucracy, "there's a mind-set that everything should be with the government," but politicians posed no resistance to the Sahiyya programme:

> "Politically, there is a lot of ignorance, they are the least bothered. Hospitals, doctors, facilities require a high amount [of funding], but there's not that much of a budget for the Sahiyya programme, so there is no resistance from that side. If there's a big programme, they will invite the Sahiyya and show appreciation."

However, the initial Health Secretary was replaced by a less enthusiastic official, putting a damper on the programme's development. This was a symptom of a government culture much more palpable in Jharkhand, where changes in the bureaucracy were more frequent than in Chhattisgarh, and hampered continuity in state-civil society relations and also destabilised the state's commitment to reform.

A second blunder was made quite inadvertently when an activist organised a team visit of bureaucrats to Chhattisgarh in 2004, in order to learn from the Mitanin programme:

> "After seeing it [the Mitanin programme], the Jharkhand team was like—this is not going to happen in Jharkhand! There was a moment of antagonism—the [Jharkhand bureaucrat] said, 'How can an uneducated woman make ORS [oral rehydration solution]! When we came back, he was totally opposed to it. He said it's too much money, too much effort."

Although civil society respondents described that they had gained confidence from their trip to Chhattisgarh, the reaction of the bureaucracy made institutionalising the programme challenging early on, with even well-intentioned attempts backfiring. Another activist attributed such government behaviour, visible in the reaction of the above bureaucrat, to the weak capacity of the state:

> "In Jharkhand, there is very little administrative experience. There is no courage to take any decision. There is not as much activism [in the state] as in Chhattisgarh. There is an inferiority complex, less self-confidence. There's an opinion that if someone else does something well, then we will fall behind [in our achievement]. That positive competition is not there, that we will do something better than others. Instead, we will keep the others beneath us."

In reality, different individuals in the government varied considerably as to their approach to the programme. The opinion of one civil society respondent was that "the government is very scared of the word 'activism' in Ranchi meetings. The Sahiyya should not be an activist." Yet, one of the previous Managing Directors (MD) of the NRHM was pleased that many Sahiyyas had become leaders in Panchayati Raj Institutions, saying, "We never thought that would be the outcome of the programme, it happened on its own." (Unbeknownst to them, two civil society actors had been aiming for Sahiyya engagement in PRIs for several

years.) Some bureaucrats even had further ambitions for the Sahiyya programme:

> "Eventually, we wanted to link [the Sahiyya programme] with development, along with health—issues like cleanliness, women's rights, witch hunting, child marriage, population control, gender, social issues."

Life histories suggested that these varied stances among individual government actors emerged during their childhood and youth. For instance, the aforementioned MD described that the intention to enter the administrative system was formed in school, while giving free tuition to poorer classmates. Government respondents in both Chhattisgarh and Jharkhand described the importance of developing 'feeling' for others, emotions that were possible to inculcate at a young age by the family, role models or one's immediate social circle. The expression of emotions such as empathy characterised benevolent bureaucrats and prevented others from having a pro-poor outlook. As an activist in Jharkhand put it: "There is little ownership of the people among individuals in government, that these are my people, my home. Here it is seen as just a job—no emotional attachment." He understood this to be partly a remnant of colonialism, bringing about a culture in governance that was not suited to indigenous ethics:

> "Even the British might have once been an emotional people. The culture that government has played up—of suppressing one's emotions—that's a real problem. It's from the pushing out of emotions that governance now begins. But when a funeral pyre is burning, people cry and cry like anything. Have you ever seen anyone in a big position doing that? Aren't people dying needlessly because of the government's neglect? Emotions are extremely important… There is a governance happening inside the human being, that accountability is ongoing. The system needs to develop it, not subvert it."

A difference in identity between government staff and the public was another factor contributing to emotional distance:

> "Most of the administrative cadre [in Jharkhand] came from Bihar—in forest, health, in universities. Others are often Adivasis. If the officer is Adivasi, and the peon is a Brahmin, then there is a lot of hassle for the officer... Because of reservations, they see SC and ST as one category, so they treat Adivasis like Dalits. They get their notions of Adivasis from books, films, and whatever they've heard they assume about them."

Emotions were considered important alongside intellect. Different benevolent bureaucrats had differing approaches to governance, with some being "systems people", focused on institution building, while others were less interested in changing rules and regulations, but more occupied with "strategic issues", promoting particular activities by Sahiyyas, and seeking outcomes "by hook or crook".

One bureaucrat was described as interested "only in systems approaches—let's create institutions, managers." Others "whip the programme to get results, they run programmes, but may not set up systems." Some were, of course, "not bothered—sitting in a chair only to react." The approach chosen by the particular bureaucrat in leadership could thus constrain or enable the potential for long-term civil society engagement.

As time went on, the take-over of the Sahiyya initiative by government also had negative effects on civil society respondents working at the grassroots, visible in the initial top-down selection of Sahiyyas:

> "All of a sudden, thousands of Sahiyyas had been selected… No *aam sabha*, no Gram Sabha. I said this in a government meeting and got shouted down—'You don't know what you're talking about'. Afterwards, the same official apologised to me, saying we were given an order the day before to select overnight… Doing it properly would have taken months. There is still a lot of tension, resentment about Sahiyyas [in this district]. The traditional *dais* [midwives] say, 'We're doing all the work, and the Sahiyya is getting all the money.'"

While there was much angst about the narrowing of democratic spaces in Jharkhand and elsewhere, the willingness of activists to

engage in substantive ways with the government was also declining. In a group discussion, several activists reflected upon the last decade of growing 'collaborative' engagements of civil society with government, and the reduction of more critical approaches. The absence of civil society unity and visionary leadership entailed an additional hurdle:

> "It's not like we planned it. If we had, we would have decided that some of us will go into government, some of us will stay outside. We should have made a strategic plan of how we will deal with government. Each person makes the decision on their own, and then realises, 'oh, you have also come, we have also come'."

> "There is a crisis of role models—of leadership. The courage needed by the political system is not there because of an absence of leadership in civil society."

> "There is also degradation of the politics, the influence of the market. People want their happiness, their facilities, they have become more self-centred, non-confrontational."

> "We've now all become co-opted by the programmes of government. Our voice has become weaker [*thoda thanda ho gaya*]. The day we take on a project mode, we need to do reporting—why's this been done, why not this—we report to government, so we become defensive. If the government is stretching us, then we will also stretch our people."

In a climate that is becoming increasingly hostile to any civil society action autonomous of government, it is unfortunate that a window of opportunity to integrate civil society presence within the state never materialised in the initial years of Jharkhand's formation. As this chapter has discussed, the particular capacity and commitments of civil society actors combined with the capacity and culture of governance so as to prevent such an eventuality.

However, as the next chapter will show, specific changes brought about in an organisation's structure can, nevertheless, alter the scope of programme activities, even within institutions that are deeply embedded within the government system.

V. Findings – Part Two: Developing Capacity and Accountability through Organisational Structure

The organisational structures of large scale programmes have major implications for the potential for rights-based action. A comparative study of how the Mitanin and Sahiyya programmes have been organised reveals how rights-based activities may be promoted even in the absence of formal institutionalised civil society leadership. The chapter first outlines the two programme structures, discussing their implications for the experiential learning and accountability required to promote different kinds of activities, and then goes on to describe some of these individual and collective activities in the field.

A. Two Different Programme Structures

In Chhattisgarh, one woman is selected as a Mitanin in every hamlet (or per 50 households, if a hamlet is smaller), such that each Mitanin serves 150 to 300 villagers. From each batch of about 20 Mitanins, a Mitanin Trainer (MT) is selected, whose role is training as well as monitoring her juniors. From all the MTs in

each block are selected 1-2 Block Coordinators (BC) and 1-2 Swasth Panchayat Samanwayaks (Healthy Panchayat Coordinators, SPSs).

The BC's role is training and supervision, while SPSs are taught that they have no supervisory role, but are providing support to juniors, particularly for collective action on the social determinants of health. About a third of the SPS's month is invested in leading social accountability via Village Health Sanitation and Nutrition Committees (VHSNCs) in which MT's and Mitanins, together with the community, monitor 29 indicators on government schemes for nutrition, education, employment, water, sanitation and health (see Appendix). From all the Block Coordinators in the district is selected one District Coordinator (DC), who again has a training and monitoring role. The training of Mitanins thus occurs in a cascade from state to hamlet-level, by the same cadre of workers who pass on monitoring data from hamlet to state-level (see Table 1). This is in sharp contrast to conventional state bureaucracies, including the Sahiyya (and ASHA) programme, where the training and monitoring cadres are separate.

Table 1 – Leadership in the Mitanin Programme

Level	Leadership Position	No. of Workers
State	State Programme Coordinator & Juniors	7
District	District Coordinators (DCs)	30
Block	Block Coordinators (BCs) Swasth Panchayat Samanwayaks (SPSs)	290 175
Cluster	Mitanin Trainers (MTs)	3160
Hamlet	Mitanins	70000

Source: Figures from hamlet to block-level reported by Programme Coordinator, Raipur (2015); figures for district and state-level taken from http://www.shsrc.org (2016).

Some of the mid-level leaders (MTs, BCs or DCs) who were selected early on in both the Mitanin and Sahiyya programme's history were brought in from the volunteers of the literacy campaign of the 1990s, and so had more of an activist background. However, individual inclinations can matter little in the face of institutional environments. Efforts were thus made by the Mitanin state-level leadership to ensure that workers at each level of the programme emerged 'from below', and so were women with past experience as Mitanins or Mitanin Trainers. Where no woman could be found for the job (many families are unwilling to let their wives/daughters travel the long distances required in rural areas, while comparatively fewer women in Chhattisgarh have the

necessary educational background[4]), or in remote or mountainous areas where dropouts are common, men were selected as mid-level leaders. Hence the proportion of women at each level reduces going up each level of the hierarchy. Nevertheless, 100 per cent of Mitanins, 85 per cent of Mitanin Trainers, 70 per cent of block-level workers, and 47 per cent of the District Coordinators are currently women, which is a remarkable achievement given the dominance of men in other state institutions across the country.

Mitanin programme leaders at each level meet regularly with their juniors and seniors (see Table 2 for frequency of gatherings). Routine collective gatherings have three main aims: mentoring juniors, ensuring their accountability, and collective problem-solving. Given that training is given by leaders from state, district, block, cluster to hamlet-level, while monitoring data is gathered from hamlet, cluster, block, district to state-level, there is a two-way flow of knowledge between the village and state.

4. Initially there was no literacy or educational requirement for Mitanins, and so 20 per cent of current Mitanins remain illiterate, with further study encouraged and supported by the SHRC. In recent years however, programme rules have ensured that new Mitanins have at least 10 years of schooling. From cluster to district-level, women are increasingly qualified and many DCs have undergraduate degrees. The ASHA programme has always demanded that CHWs have passed class 8.

Table 2 – Leaders & Collective Action Forums in the Mitanin Programme

Level	Leader	Collective Action Forum	Frequency of Collectives	Community Participation	State Participation
Hamlet	Mitanin	Mitanin *baithak* (meeting)	Monthly	✓	-
Two hamlets	Mitanin	Joint Mitanin *sankul baithak*	Monthly	✓	-
Village	MT (Mitanin Trainer)	VHSNC meeting (Village Health Sanitation Nutrition Committee)	Monthly	✓	Panchayat & other health workers
Two villages	MT	Joint VHSNC meeting	Bi-monthly	✓	-
Panchayat	[Sarpanch]	[Gram Sabha]	Three monthly	✓	Panchayat & other health workers
Block	BC (Block Coordinator)	MT meeting Mitanin training MT training	Monthly Annual Annual	- [+External civil society]	- Block Medical Officer
	SPS (Healthy Panchayat Coordinator)	Sammelan (public hearing) [Protest]	Annual As needed	✓ ✓	State officials & Panchayat leaders
District	DC (District Coordinator)	BC meeting BC training [Protest]	Monthly Annual As needed	- - ✓	Block Programme Manager -
State	*Juniors*: Associate/ Coordinator	SPS meeting	Monthly	Associates, Coordinators, Senior Coordinator	-
	Seniors: Senior Coordinator	DC meeting	Monthly		[State Nodal Officer]
	Director	DC training	Annual	[+External civil society]	-
	Governing Body	Governing Body meeting	Annual	Affiliated civil society	-
As needed	As needed	Meetings for specific causes	As needed	[✓]	-

This two-way flow differs starkly from the Sahiyya (and ASHA) programme, and has a number of implications that become evident following a discussion of the Sahiyya structure.

In the Sahiyya programme, each Sahiyya serves a population of 1,000 villagers, as per ASHA guidelines, and so Sahiyyas are more sparsely distributed across the population than Mitanins. Collective action by Sahiyyas and their seniors is thus much more difficult. In remote areas where hamlets are very distant from one another, allowance was made to allow one Sahiyya per 200 villagers.

Each group of twenty Sahiyyas is supervised by a Sahiyya Saathi. The trainers of Sahiyyas are the Block Training Team (3-4 in each block), who are themselves trained by the State Training Team (1-2 in each district). In parallel to the training staff are the monitoring cadre of District Programme Coordinators (see Table 3 for numbers).

The Sahiyya Saathis are selected through discussion and voting by the Sahiyyas themselves. Mitanin Trainers, in contrast, are chosen through a written test (to avoid local corruption or political interference). I attended one Sahiyya Saathi selection event where

there was little debate by Sahiyyas on who would be their leader. It also seemed as if the Block Training Team (BTT) member had won the agreement of the Sahiyyas on who was most suited for the job. The BTT explained that only one Sahiyya among them was proficient in both speech and literacy, while the Sahiyyas present nodded along.

Table 3 – Leadership in the Sahiyya Programme

Level	Leadership Position	No. of Workers
State	State Programme Coordinator & Juniors	3
District	District Programme Coordinators (DPCs) State Training Team (STT)	24 45
Block	Block Training Team (BTT)	~700
Cluster	Sahiyya Saathi (SS)	~2400
Hamlet	Sahiyyas	~45000

Source: Figures reported by programme junior at State-level (2016).

A civil society respondent in Jharkhand suggested that the "weakest link" in the programme was the Sahiyya trainer (the Block Training Team). In Chhattisgarh, the weakness of Mitanin training was attributed to "transmission loss", which was highest between the State and district level, the level at which the gap in educational qualifications was also the greatest. However, in Jharkhand, weak training was attributed by civil society

respondents to the unwillingness of powerful state actors to provide medical knowledge to villagers. One activist suggested:

> "The government doesn't want to give them too much information. [Their idea is] we won't teach her because then she won't bring patients to hospital. The medical lobby would also never want people to gain knowledge. There are ANMs [Auxiliary Nurse Midwives] who have been working here for two years, but they haven't conducted any deliveries yet."

A significant limitation to Sahiyya as well as Mitanin training was the fact that the budget permitted only 5-6 days of training per year. Programme members in both States recognised that the quality of work would be considerably weaker with such minimal training. Yet in the Mitanin programme, the frequent interaction of Mitanins with their seniors allowed capacity to be built through regular discussion. In Jharkhand, formal meetings between junior and senior workers were less frequent (see Table 4). Due to the distant residence of BTTs from Sahiyyas, casual meetings between them were uncommon. The Block Training Team member neither had experience of being a Sahiyya, nor was he (being male in most cases) from the same locality or educational or cultural background. In other words, the mid-level leadership was somewhat cut off from the frontline worker.

Table 4 – Leaders & Collective Action Forums in the Sahiyya Programme

Level	Leader	Collective Action Forum	Frequency of Collectives	Community Participation	State Participation
Village	Sahiyya	VHSNC meeting (Village Health Sanitation Nutrition Committee)	Monthly	✓	Panchayat & other health workers
Cluster	SS (Sahiyya Saathi)	Cluster meeting	Bi-monthly	✓	-
Panchayat	[[Sarpanch]]	[[Gram Sabha]]	Quarterly	✓	Panchayat workers
Block	BTT (Block Training Team member)	Block meeting	Monthly	-	*MOIC* (Medical Officer In-Charge)
		Sahiyya/SS Training	Annual	-	
	STT (State Training Team)	CBM (Community-based monitoring)	Annual	-	Health dept officials & Panchayat leaders
		BTT training	Annual	-	
District	STT	District meeting	Monthly	-	✓
	DPC (District Programme Coordinator)	CBM (Community-based monitoring)	Annual	-	Health workers & dept officials
State	*Juniors*: Community Mobilisation Cell staff	[Sahiyya Sammelan]	Annual	-	✓
		State meeting	Quarterly	-	✓
	Senior: SPM (State Programme Manager)	Annual General Meeting	Quarterly	-	✓
As needed	*Civil society affiliates:* NGO/ ex-programme members	Meetings for specific causes	As needed	[✓]	[SPM, DPCs, STTs]

Although BTTs had more clarity and confidence than Mitanin Trainers, and their teaching methods were more varied and interesting, I saw that Sahiyyas were often reluctant to discuss their misunderstandings or questions with trainers who represented a higher status to their own (more often being male and better educated). There was also a greater language barrier between BTTs and Sahiyyas who were not fluent in Hindi, than between Mitanins and their trainers.

In the Mitanin programme, where the majority of leaders at each level emerge 'from below', and where meetings are held more closely between successive programme levels, allowing for the two-way flow of information, frontline and mid-level workers can collectively engage in tackling social crises as they arise in the field, with close support provided by seniors. State-level schemes can be designed in a flexible manner and modified for diverse local settings, as required during implementation itself. Local knowledge can be used for priority setting and for advancing existing policies. Workers at each level also develop an understanding of what is happening above them as well as below them, gaining a grasp of management and planning skills, while ensuring their guidance is more relevant to the needs, culture and understanding of the

people. As one block-level worker put it, "We learn from the ground, and we also learn from the roof [*hum zameen se bhi seekhte hain, aur chhat se bhi seekhte hain*]."

Structuring Relations of Accountability

Most significantly, such an organisational structure maintains the downward accountability (Fox, 2014) of leaders at each level, minimising corruption in a number of ways. Firstly, junior leaders become answerable to seniors who have either emerged from their own context, or have been immersed in it. The Governing Body of the Mitanin programme is its most significant authority, being composed of civil society activists who preserve the values of the programme, and have the power to replace the programme's leadership if it deviates from a pro-poor agenda – thus *capturing downward accountability within upward accountability*.

The presence of a series of collectives at each programme level, in which most leaders emerge from the level below, ensures that as Mitanin workers rise from the village, block, district, and (in a few cases) to the state-level, their legitimacy remains dependent on those among whom they continue to live and work: the village community and their co-workers. Within the close-knit community

of the hamlet, field workers regularly interact with communities, even at higher levels of the programme hierarchy. Such interactions build informal mechanisms of downward accountability through social pressures. In contrast, the disconnect between frontline workers and mid-level leaders in the Sahiyya programme can limit the ability of senior workers to identify instances of corruption among juniors.

Informal mechanisms of downward accountability act even more effectively at higher levels of the Mitanin programme hierarchy, such that rising leaders in the programme are unable to "insulate themselves from internal critics," in contrast to the organisational structure of a political party (Wyatt, 2010, p.247). Any growing material wealth of members is soon noticed by fellow and junior workers, who remain competitively watchful of their friends and seniors, quick to report suspicions to the state-level. Tendler has (1997) described similar dynamics of accountability in a health programme of northeast Brazil that helped to minimise rent-seeking. One example of this was in the case of a Mitanin who accepted a bribe to stand against another Mitanin Trainer in block Panchayat elections, splitting the votes between them. The Mitanin was then removed from the Mitanin programme.

While the senior leadership's familiarity with the character of their juniors was more limited in Jharkhand, several examples were given in other districts in Chhattisgarh of workers investigated by the SHRC and removed following evidence of corruption. For instance, a mid-level worker was asked to leave after claiming travel expenses for a train journey when the travel was actually by bus. Such instances strengthened the integrity of existing workers. Interviewing an SPS near the start of my fieldwork, I found that she had been keeping daily diaries years before joining the programme. I asked if I could read her diaries and she kindly agreed. But at the time when I offered her a gift, she responded, "No, no, if anyone in the programme finds out I will be removed!" The threat of exclusion appeared to preserve her integrity even in minor issues.

B. A Range of Activities Ensue from a Programme Structure that Facilitates Experiential Learning

Building Capacity through Routine Health and Social Activities

The most common activities of Sahiyyas, like Mitanins, are on medical issues. They motivate community members to avail of health services such as immunisation, antenatal care, postnatal care, and the consumption of iron and folic acid tablets. Sahiyyas

assist in the identification and referral of patients with tuberculosis, leprosy, malnutrition, and cleft palate, and counsel adolescent girls on nutrition, hygiene and life skills as potential mothers. In addition, since 80 per cent of Sahiyyas (and Mitanins) are literate, they can help villagers with other activities like filling up government forms. Like Mitanins, I found several Sahiyyas assisting villagers to acquire disability certificates, get death certificates made for widow's pensions, and access pensions for the elderly. Although illiteracy among Sahiyyas was often described as a problem by senior programme workers, training manuals gave a 60/40 weightage to pictures and words, and efforts were made in training sessions to boost their confidence. As one Block Training Team member exclaimed to a room full of about 80 Sahiyyas, "If you work with intelligence and understanding, then you can beat any person who knows how to read and write!"

There were many times when literacy, or rather education, was criticised by programme members in both States. For instance, one civil society respondent in Jharkhand described:

> "You have to say exactly what is written in the book—that's what our education system teaches us. And we have to give replies in that same way. What has been taught to us—that is the limit to which we can think."

Such habits were perceived as barriers to promoting rights-based action among those with education. In Chhattisgarh too, block-level workers described their BA degrees as providing them with only "bookish knowledge [*kitabi gyan*]". Rather, knowledge from the field was considered more real and relevant.

Occasionally, Sahiyyas and Mitanins would both be asked by other health workers such as Auxiliary Nurse Midwives (ANMs) and Anganwadi nutrition workers (AWWs) to assist them in their own work. As one mid-level worker in Jharkhand put it, "Angwanwadi workers have become a bit too *sarkari* here. If they have too much work, they will call the Sahiyya over." Some Sahiyyas, like some Mitanins, were found to take patients to private hospitals. In one private clinic for family planning, the patients were charged Rs. 1,000 to 1,500 for a non-scalpel vasectomy, while the Sahiyya would be paid Rs. 500 by the clinic. Although many Sahiyya programme staff saw this as a reason to have Sahiyyas removed from their post, this was only possible when the Gram Sabha resolved to do so with the agreement of villagers. However, in several areas, I found that villagers were unaware of the fact that they could replace inefficient Sahiyya workers. In contrast, the power to dismiss Mitanins lay among senior programme workers,

and as discussed above, several Mitanins (and mid-level leaders) had been asked to leave following investigation by their seniors for inefficiency, corruption and/or politicisation. Although the idea of giving the Gram Sabha such powers was thought to enhance the people's ownership of the Sahiyya, and hence her accountability to the community, such an expectation seemed valid only in theory. Expecting the Gram Sabha to always take action against Sahiyyas appeared to be a tall order.

On several occasions, private hospitals actively offered payment as an incentive to Sahiyyas and Mitanins, but in other situations, the women would demand that they be paid per patient referral, as they would be in a government hospital. One civil society respondent in Jharkhand saw this positively:

> "Look at that lady—she has guts! [The Sahiyya shouted] 'My patient came to you, so give me Rs. 500!' I was happy from the inside, that the Sahiyya is able to assert herself."

Most Sahiyyas had indeed become more assertive through their experiences in the programme. Like Mitanins, their exposure to the world outside the village, opportunities to engage in discussions, give health advice, and interact with hospital staff (who did not always make their work easy), had enhanced their

confidence and ability to negotiate with relatively more powerful members of the village as well as officials.

Prior to entering the programme, most Sahiyyas had not engaged in any voluntary or paid work, other than routine farm or domestic work. Some had been part of Self-Help Groups (SHGs), a few were members of NGOs, and some had done tailoring work. They described that the most enjoyable part of their Sahiyya work was "roaming about in the area," "chatting with one another," "gaining new knowledge," "recognition and respect," and "having the opportunity to serve."

Such motivations were comparable to Mitanins, although Mitanins who had been promoted to the position of Mitanin Trainer, Block Coordinator or District Coordinator, described a progressive enhancement of their leadership capabilities. As Mitanins, the women had gained detailed knowledge of the roles of the ANM, Angwanwadi worker, Sarpanch and other functionaries, and had some awareness of government schemes for nutrition, employment, education and sanitation. As Mitanin Trainers, they began to compare and contrast the performance of government workers in different Panchayats, and developed a wider

understanding of state welfare schemes. As Block and District Coordinators, they were able to negotiate with state functionaries with more confidence, often demanding entitlements from them. Much of the capacity building in the programme thus arose from practical experiences in the field, rather than formal training.

Most Sahiyyas who had become leaders in PRIs similarly showed evidence of previous work that had helped in developing their confidence, analytical and leadership skills. Several Sahiyyas had benefitted from the skills as well as social capital accrued from being part of Self-Help Groups (SHGs). In several areas, SHG women as well as Sahiyyas had actively helped in their election campaigns. One Sahiyya Saathi, who had become Mukhya (and hence had to leave her Sahiyya Saathi post), described that she was from a Bengali family, where education had been promoted much more than she found among her tribal neighbours. She had initiated her own NGO before becoming a Sahiyya. Yet in comparison to Mitanins who could rise up the programme hierarchy, Sahiyyas could not be promoted beyond the level of Sahiyya Saathis, with the large part of the latter's role invested in monitoring Sahiyyas rather than building their capacity.

According to programme rules, Sahiyyas were not allowed to work with any NGOs, but could stand for Panchayat elections. However, rumours had been spread in many areas that Panchayat leadership by Sahiyyas was not permitted, and so in some Panchayats they had been prevented from participating in elections. This was not the case in Chhattisgarh, since Mitanins and their workforce were all embedded in an NGO structure, and were less likely to be seen as *sarkari* (government) workers. Sahiyya programme seniors did repeatedly clarify this misunderstanding with workers, and clarifications were also made in writing by the State-level administration.

Experiential Learning Encourages 'Spontaneous' Collective Action

A point of departure of the Mitanin programme is the supplementary role given to referral and curative care, with greater emphasis on a rights-based approach in the training and support given to Mitanins (Sundaraman, 2003). While there have been rapid declines in infant mortality rates (IMR) in Mitanin-served areas (as compared with a static IMR in urban areas where the programme was not running), improvements in breastfeeding practices, ORS use, health-seeking behaviour for respiratory

infections, and community attitudes towards death and disease, "[m]ost importantly… [the programme] has brought back credibility to the role of community participation in health sector reform and has given the whole health sector reform process a renewed confidence and dynamism and public visibility and grassroots support," (Raman, 2007).

One of the advantages of strong institutionalisation is that instances of rights-based work can easily be documented qualitatively by workers, with such documentation collected at State-level. Mitanins are known by senior leaders to have mobilised communities to demand entitlements from the state such as for food and nutrition programmes, immunisation camps, drug supplies and access to safe water; they have acted against the irrational use of medication by private practitioners and government workers; they have mobilised against corruption in schools, Anganwadi Centres (AWCs) and Primary Health Centres (PHCs) (Nandi, 2005, p.18-23); campaigned against deforestation and for the securing of rural livelihoods (Kohli, 2006); and fought against alcoholism and domestic violence in the community (Nandi, 2012, p.114). Monitoring data from the programme reveals

that in 2011, Mitanins around the State acted against 1,860 cases of domestic violence per month (*ibid*, p.31).

Sahiyya activities were less well known to the senior-most leadership in Jharkhand. As I found on my visits to 7 districts, some Sahiyyas had made attempts along with other village women to stop domestic violence in their area, as part of the training provided in the ASHA programme, but they had rarely been successful. As one Sahiyya described:

> "There was one woman whose husband used to beat her a lot. I said to him [to stop], I told him off very strongly. But he said to me, 'I can do whatever I want with my wife.' The man used to beat his mother also. I didn't find any solution for that."

A distinguishing feature of the Mitanin programme that enables higher levels of collective action is the field-based presence of its mid-level leadership, most of whom have prior experience of working as Mitanins. Most Mitanins alone have little confidence to engage in collective action, especially activities that could pose high risks to participants. Even Mitanin Trainers would hesitate to speak boldly in public without the presence of their Block or District Coordinator. Yet together, they provided both the numbers as well as voice for exerting pressure on families engaged

in domestic violence, or on state officials engaged in corruption. The DCs in particular would encourage junior workers to be less accepting of abuse from government officials, and in one area a district-wide protest was held against a Chief Medical Officer, who had verbally insulted a Mitanin Trainer. This protest itself had built upon a recent experience of mobilisation in which the child of a Mitanin Trainer had been killed, and the workers of the programme had organised a protest outside the District Collector's office to have the murderer jailed. Here again, the close and capable leadership provided by Block and District Coordinators had been critical in motivating action, rather than accepting that the murderer, like other powerful landowners, would be able to buy his way out of justice.

Programme leaders in Jharkhand described that the rights-based activities of Sahiyyas had been more common in the early years of the programme, though there was no quantitative data available to clarify this.[5] One activist affiliated with the programme suggested that repeated Sahiyya training had over the years caused their

5. Although data on health and social activities by Mitanins was recorded quite systematically by the State Health Resource Centre's Mitanin Information System (MIS), there was no such comparable data collection method in the Sahiyya programme.

engagement in rights work to diminish, such as mobilising against corruption in the local hospital, since training promoted a passive environment of simply following instructions. Recent instances of collective action that I came across in Jharkhand included the management of a diarrhoea outbreak by Sahiyyas in one district, followed by the organisation of a health camp together with the Health Department. There were no notable activities ongoing of confrontational claims-making (except in CBMs), against either the government or the private sector. One civil society member reported that Sahiyyas had been trained on the Right to Information Act, but not as part of the regular training course, and only in a few places.

Respondents also described varying levels of action by Sahiyyas depending on their background—Munda and Oraon Adivasis tended to be 'stronger' as compared with those of Chaibasa, and had more education and social capital to promote social accountability. In the Mitanin programme, workers from a wide range of identity groups were able to engage in discussions and meetings, and so learn from one another. Given that the principal actors expected to lead collective action in Jharkhand were the Sahiyyas or Sahiyya Saathis of each local area (in contrast to block

or district workers in Chhattisgarh), the opportunities to learn from the experiences of different blocks or districts, or from different identity groups, was limited. Such learning was facilitated in Chhattisgarh through the Mitanin Paati—a quarterly newsletter that was disseminated across all programme staff.

Social Accountability through Village Health Committees

In 2014, Chhattisgarh was considered the 'best practice state' for running Village Health Sanitation Nutrition Committees (VHSNCs) in the country. Jharkhand had extremely weak VHSNCs in comparison to Chhattisgarh. The Jharkhand Sahiyya leadership suggested that this was due to their lack of attention to VHSNC training, which had only been given to Sahiyyas four times since the programme's initiation—in 2004, 2008, 2009 and 2010. However, the leadership skills that Sahiyyas needed to build in order to conduct a VHSNC meeting were not the kind that could be built in a classroom—as evidenced by the fact that Mitanins, and even Mitanin Trainers, were far less capable of leading a VHSNC than SPSs. The SPSs had benefited from much more experiential learning through their previous work in the field as MTs, and were given monthly training in Raipur, with dedicated mentoring on how to deal with the challenges of community

participation and social accountability. A similar cadre of workers in Jharkhand, emerging from the Sahiyyas themselves, would allow VHSNCs to be led by a more effective and experienced leadership.

In developing such a cadre, the selection process would be critical. The 175 SPSs of Chhattisgarh (as of 2016) are by and large women selected from each batch of MTs through a rigorous process of interviews, written tests and group discussions, with the latter assessing their pro-poor values and past evidence of 'speaking truth to power'. The critical ingredients for rights-based action, empathy and courage, essential for the social accountability work of VHSNCs, were thus brought into the SPS cadre at the time of selection. This selection process was a vital step given that both compassion and will power were much harder to develop among workers at a later stage. The failure of VHSNCs in Jharkhand was attributable to the fact that there was no cadre equivalent to the highly motivated block-level SPSs who could provide leadership support to VHSNCs, a cadre without whom VHSNCs in Chhattisgarh would never have been as efficient. The senior leadership of the Sahiyya programme frankly stated that they had the autonomy (from NRHM guidelines) to provide a dedicated

leadership for VHSNCs, at least at the state-level, but had not yet done so.

Social Accountability through Community-based Monitoring (CBM) Hearings

The gatherings for Community-Based Monitoring (CBM), also known as *jan sunwais* (public hearings) or 'Sammelans' in Chhattisgarh, were quite different in the two States in terms of organisation, content and community participation. The process by which CBMs have been scaled up demonstrates a stark difference in management, with Chhattisgarh being centrally expanded at the State-level, and Jharkhand showing district-centred management, ultimately resulting in greater power being in the hands of the community and Mitanins in Chhattisgarh, with a wider range of issues discussed, but with weaker capacity to respond to oppressive state officials (as far as was visible during the event itself).

In Chhattisgarh, Sammelans were initially piloted in one block of Koriya district, and in 2013 scaled up to one block of each district, and since 2014 have occurred in each of the 146 blocks across Chhattisgarh. In Jharkhand, they are now held once a year in about

a quarter of all 260 blocks, with the aim to scale up within each district. Among the 18 blocks in Ranchi district for instance, the first CBM was held in Angara in 2009, followed by Ratu block in 2011, and then one additional block each year until CBMs were held in 6 blocks in both 2015 and 2016, namely Ratu, Bero, Tamar I, Sonahatu, Namkum and Angara.

Photo: Arshima

Picture 2: ANMs and Sahiyya workers at Angara CBM, Jharkhand

At a CBM held in June 2016 in Angara block of Jharkhand, an audience of about 200 Sahiyyas and Sahiyya Saathis as well as

about 30 ANMs raised their demands to a panel of state officials, including the Block Medical Officer, Medical Officer In Charge (MOIC), Civil Surgeon, Chief Medical Officer, and Deputy Commissioner.

Others present included PRI members, the Sahiyya programme's Block Accounts Manager, Block Programme Manager, and Block Training Team members.

In Chhattisgarh, the panel consisted of five state officials from different departments, mainly education and health, with the Chief Executive Officer (CEO) responding to complaints. Many Mitanins had brought with them a few villagers from their hamlet who voiced their needs, mostly for elderly pensions, widow pensions (one woman had not received her pension for 10 years), and disability cards.

Photo: Arshima

Picture 3: Elderly lady demanding her pension. Microphone held by Swasth Panchayat Samanwayak (block-level Mitanin programme worker)

Other demands raised by Mitanins included general needs in the village such as fixing of water pumps and delivery of MGNREGA wages, as well as Mitanin needs such as timely payments.

Unlike the Mitanin programme, rigorous training was provided by district workers to Sahiyyas for 15 days prior to the CBM, so as to rehearse the force, unity and order in which complaints were raised. In a CBM in Angara for instance, I found that Sahiyyas would individually stand up to make their voices heard when issues were less controversial, such as complaints about payments delayed for months, or their having to stay for 3 days in hospital

for a delivery, when their own children were not looked after at home. However, when their grievance was against a corrupt accountant in the Health Department, they were careful not to make their own identity known, and would stand up in a crowd and shout out together.

In a panel of eight state department representatives, only two showed genuine interest in resolving the dilemmas faced by Sahiyyas. One lady official did not say a single word in the four hour proceedings, and was constantly engaged on her mobile phone whenever she was not visibly asleep. A senior male official spent much of his time responding to complaints, but wherever possible would reprimand the Sahiyya, turning around the complaint to question her accountability: "Why did you not come to us at the time with this complaint?" "It is your responsibility to make sure patients have opened their bank accounts." Some attendees did feel that the CBM has over the years assisted in reducing corruption, given the public humiliation that officials have to face: "Those who used to give bribes, fear has crept into them." Although the District Programme Coordinator (DPC) described that grievances are supposed to be addressed within 15 days, and monitoring of the CBM occurs after one month, two

months following the CBM in Angara (August 2016), no data had been collected at the State-level on the resolution of complaints.

The DPC was the lead organiser of the CBM in Jharkhand, and the event was held under the chairmanship of the Deputy Commissioner at district-level. The DPC in Ranchi negotiated heavily between Sahiyyas and state officials, and he believed that "if an NGO was running it, the authority wouldn't be there, they wouldn't be able to implement forcefully. Our CBMs are all run by the government," he said with pride. In contrast, the State-level programme leadership recognised that "Fifty percent of CBMs are 'managed'… Political leaders are also taking an interest… We are a little upset that CBM is managed now… DPCs are also not providing data."

In Chhattisgarh, the main Sammelan organisers were the District Coordinator (DC) and Swasth Panchayat Samanwayak (block-level SPS), with the assistance of Block Coordinators, Mitanin Trainers and Mitanins, who together took charge of the event. Although the main speaker facilitating dialogue was the DC, she was at times dominated by the CEO. The event visibly helped Mitanin programme women as well as villagers to build their capabilities to

assert themselves in front of powerful officials, and gain skills to organise such events independently in future. The trade-off was that in the process of capacity building and citizenship training, the immediate results of pressurising officials to promise change within the CBM appeared more likely in Jharkhand, where an urban professional (the DPC) was able to train Sahiyyas in advance, and question state officials more forcefully. However, estimates of the extent to which CBM demands were met in the long term varied, with feedback that many complaints remained unaddressed in both States. Quantitative data is required that can independently compare the performance of the two States.

VI. Conclusion

The Sahiyya and Mitanin programmes are both precursors to the national Accredited Social Health Activist (ASHA) scheme, launched in 2005 as part of the National Rural Health Mission (NRHM). Fifteen years on, the Sahiyya scheme in Jharkhand resembles the design of the ASHA programme in many other states, with Sahiyyas working mostly on health service provision, and engaging in rights work only sporadically, when the combination of individual agency and local crises are heightened enough to spontaneously promote collective action. This study has explored the reasons underlying the different activities visible in the Mitanin and Sahiyya programmes, by examining the enabling and constraining factors for social accountability at village, block, district and state-level.

Although the culture of governance in Jharkhand prevented the integration of civil society engagement, and the skills and varied commitments of civil society actors further hampered social accountability, spontaneous work on rights has been visible in the Sahiyya programme. However, the Mitanin programme succeeded

in creating a particular organisational structure that has so far allowed its rights-based activities to expand over time and in scale. Yet, as Husain (2011, p.57) points out:

> "the [ASHA] scheme requires the volunteers to play an activist role in communities which are often characterised by religion and caste politics, conservative attitudes and where women are still looked down upon. Expecting partially trained local volunteers to adapt to the complex dynamics of Indian rural communities and effect an immediate radical change in the situation is expecting too much."

Nevertheless, looking to the future, advocates of an optimistic view remain. Hope for the social accountability role for ASHAs emanates to some extent from the experiences of the Mitanin programme, from which the ASHA (Hindi: lit. 'hope') was at least partly inspired. Work towards revolutionary change may be a long way off. Yet as a civil society member in Jharkhand put it:

> "For a big victory, you need to win on a small-scale. The space for that has also reduced."

Whether collective action in Chhattisgarh has been organised at local or district-level, each instance of mobilisation has contributed to the next, building capacity and social capital for progressively more intensified action at a larger scale. Current strategists would do well firstly to look out for windows of opportunity for

engagement with other actors, bearing in mind dominant cultures and capacities of government, and to create networks of solidarity and unity that can be built into institutions in the future. Envisioning large-scale institutional designs, as well as making persistent and tactful attempts to develop such institutions, is essential. In the absence of this, piecemeal attempts to direct the agenda towards communities are likely to fall short, given that any institutional vacuum is bound to be filled by the existing priorities of the system with all its vested interests, making frontline workers answerable largely to those above them.

A necessary overarching strategy would be to use a systems approach, building an institution in which the cascade of leadership emerges from the *bottom up*. Here, leaders at each level arise from below, and frequent and close collective interactions need to be formalised between each level. A dedicated leadership is required to build the capacity and accountability of each of these collective forums, in particular those embedded in the community such as village health committees. In the selection and supervision of leaders, it is essential to maintain an experience-based approach. Most importantly, strengthening the accountability of state institutions to the people requires that upward accountability is

directed to leaders at each level of the organisation who have substantial experience of working with the people. In the Mitanin case, State-level leaders are brought to account by a governing body comprised of civil society actors who have a long history of grounded experiences, demonstrating their values as well as commitment to the people. Upward accountability can thus be built upon real processes of downward accountability, beginning with the senior most leadership.

A final essential long term strategy would be to develop individual traits of leadership, by learning from both the activists and state actors in Chhattisgarh and Jharkhand. There appear to be certain critical ingredients of individual character: conscience, courage, empathy and independent thinking, required within civil society, government, donor agencies and academia, which can bring about alternatives to the way governance is heading. More individuals are needed who are willing to engage practically with the marginalised in local settings, as well as negotiate with actors at higher scales, while advancing their analytical critique of local experiences and political negotiations, in conjunction with an understanding of the literature.

The Mitanin and Sahiyya initiatives question the dominance of policy actors who suggest that only highly qualified medical practitioners can improve the health system. While physicians need to be better sensitised during and after medical education to care for rural communities, there are fundamental ways in which female health workers, emerging from the village, can also strengthen primary health care. Basic treatment, counselling, and triage are services that do not require specialised medical training, and can be taught to villagers with minimal school education, provided that the training is well-funded, regular and based on field experience. It remains essential to increase funding to the ASHA programme across the country, so as to provide far more than the current 5-6 days of training they receive annually. Comprehensive training is of the essence.

Moreover, in areas where improving health requires activities on social accountability, community health workers can play an essential role in promoting the right to health and social determinants of health. However, both the service provider and rights-based role of the frontline worker require organisational structures and institutional processes that allow leaders at each programme level to direct their potential to those most in need. In

the short-term, leaders of health programmes have much to learn from the Mitanin example, which despite its limitations continues to provide inspiration to many in the health sector across the country, and indeed around the world.

Appendix – Health & human development indicators monitored in Village Health Sanitation Nutrition Committees of Chhattisgarh

No.	Indicators	Jan	Feb	Mar
	Anganwadi Centre			
1	Did all Anganwadi centres open regularly during the month?			
2	No. of children aged 3-6 years			
3	No. of children aged 3-6 years who came regularly to Anganwadi centre			
4	No. of 0-3 year children in village			
5	No. of 0-3 year children who are in malnourished or severe malnourished grade			
6	Was the weight measurement of children done in all centres last month?			
7	Were pulses and vegetables served all days in cooked meal last week in all centres?			
8	Was Ready to Eat food distributed in all centres on each Tuesday during the last month?			
	Complementary Feeding			
9	No. of children aged 6-9 months whose complementary feeding has not started yet			
	Health Services			
10	Did the ANM come last month for immunisation/VHND?			
11	Were all children of all hamlets vaccinated at appropriate age?			
12	Was BP measurement of pregnant women done in the VHND?			
13	Did ANM provide medicines to patients free of cost?			
14	Did all ASHAs have more than 10 chloroquine tablets with them?			
15	Did all ASHAs of the village have more than 10 cotrimoxazole tablets?			
16	Was transportation facility available to take serious patients, delivery cases, sick new-borns etc. to health facilities?			
17	No. of families not using mosquito net			
18	No. of deliveries that took place at home in last month			
19	No. of diarrhoea cases during the last month			
20	No. fever cases during the last month			
	Food Security			
21	Did PDS ration shop provide all ration items during the last month?			
22	Did old age pensioners get pension on time?			
23	Were MGNREGS payments made in time?			
	Education			
24	No. of girls aged 6-16 years not attending school			
25	Did all school teachers come to schools regularly during the last month?			
	Mid-Day Meal			
26	Were pulses and vegetables served all days last week in cooked meal in all schools to 8th standard?			
	Water and Sanitation			
27	How many hand pumps are non-functional today?			
28	No. hand pumps with stagnant water around them today?			
29	No. households with individual latrines constructed and used			
	Status of women			
30	No. of cases of violence against women during the last month			
31	No. of cases of early childhood marriages reported			

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Arshima's research involves an interdisciplinary exploration of the theory and practice of accountability spanning state and society. Following a few years of work experience as a medical doctor, she volunteered to do development work in rural Bihar, where 81% of the population lives in poverty (according to multidimensional indicators). Her doctoral thesis at the India Institute, University of London, explored the individual and institutional enablers of accountability in the rural health and development system in Chhattisgarh and Bihar. The study has made a signal contribution to interdisciplinary research and was well received at conferences on anthropology, political science, development studies, theology, and health policy and systems research (HPSR) in New Delhi, Cambridge, Portsmouth, Madison, Cape Town and Bucharest.

Arshima's first book project is titled Accountability from Village to State: How can state institutions become worthy of public trust? The endeavour rests on a grounded theory study of the Mitanin programme, a community health worker scheme training 74,000 women in villages and slums across Chhattisgarh, initiated by the State government and led by civil society. In ethnographic fieldwork carried out over a year, Arshima explored activities from village, block, district to State-level that have led to altered health-related behaviours in the community, reduced caste discrimination and gender-based violence, and improved rural sanitation and education.

Arshima's study also investigates social accountability efforts by Mitanin programme workers to tackle corruption in state nutrition schemes, campaign against the acquisition of tribal land, win a year-long legal battle against the State Forest Department, and fight for elected leadership positions in Panchayati Raj Institutions. These activities were compared with women's action in the Accredited Social Health Activist (ASHA) programme in Bihar, and in Panchayats more widely in India.

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