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Community health worker programs in India: a rights-based review

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Abstract

This article presents a historical review of national community health worker (CHW) programs in India using a gender- and rights-based lens. The aim is to derive relevant policy implications to stem attrition and enable sustenance of large-scale CHW programs. For the literature review, relevant government policies, minutes of meetings, reports, newspaper articles and statistics were accessed through official websites and a hand search was conducted for studies on the rights-based aspects of large-scale CHW programs. The analysis shows that the CHWs in three successive Indian national CHW programs have consistently asked for reforms in their service conditions, including increased remuneration. Despite an evolution in stakeholder perspectives regarding the rights of CHWs, service reforms are slow. Performance-based payments do not provide the financial security expected by CHWs as demonstrated in the recent Accredited Social Health Activist (ASHA) program. In most countries, CHWs, who are largely women, have never been integrated into the established, salaried team of health system workers. The two hallmark characteristics of CHWs, namely, their volunteer status and the flexibility of their tasks and timings, impede their rights. The consequences of initiating or neglecting standardization should be considered by all countries with large-scale CHW programs like the ASHA program.

INTRODUCTION

Community health worker (CHW) programs are an integral part of health care initiatives for marginalized communities. Several developing countries today have large-scale CHW programs. We now know that such programs can contribute successfully when appropriate selection, training and ongoing support are provided. On the other hand, numerous large programs have failed in the past due to unrealistic expectations and poor planning.[1]

The high attrition rates in CHW programs are now well acknowledged. Monetary and non-monetary incentives, community involvement, supportive legislation and trust-building among health professionals are demonstrable factors in preventing attrition.[2] However such measures are not always a part of CHW programs, despite the reported positive impacts.

Prasad and Murleedharan[3] report a range of favorable health outcomes achieved by CHW programs in various communities. They also present some features that are common among the CHWs working in successful programs. These common features give some indication of the reasons why service reforms for CHW programs are overlooked and CHWs are unable to secure better service conditions for themselves.

The first common feature is the gender of the CHWs. Most countries have female CHWs, and there is a widespread belief that women are more effective as CHWs. The second common feature is that these female CHWs are from the local community, and third, they are generally only school-educated. The authors note that while the performance of CHWs is not found to be related to their education, age, sex, or number of offspring, those CHWs with further education are likely to look for better opportunities. The fourth common feature is that the lack of future career prospects

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linked to being a CHW serves to increase the dropout rates in CHW programs.[3]

Thus, even in well-functioning programs, CHWs often have little space to negotiate for themselves at work, due to their poverty, gender, lower educational levels, poor exposure and the lack of growth opportunities. It is therefore necessary to take a rights- and gender-based perspective of CHW programs in order to strengthen both the CHWs and the programs. This is particularly relevant for government - run CHW programs as they provide important public health services in the poorest and most remote communities.

India has a rich tradition of implementing small area-based programs as well as large-scale CHW programs in its villages. Most of these programs enlist local woman as CHWs. This is true of both the not-for-profit/voluntary organizations as well as governmental ones. This article presents a historical policy review of the evolution of CHW programs in India using a gender- and rights-based lens. India has had three successive large-scale government run CHW programs. An evidence-based review of the rights-based issues regarding the CHWs in these programs is also presented. The article discusses the evolution of these programs by looking at the perspectives of the stakeholders, the gaps in policy and the way forward regarding the rights of the CHWs. The aim of the article is to derive relevant policy implications in order to stem attrition of CHWs and enable sustenance of large-scale government run CHW programs in India and other countries.

METHODS

A two-fold strategy was used for the literature review. First, relevant government policies, minutes of meetings, reports, newspaper articles and statistics were accessed through official websites. Second, a search was conducted for studies on the rights-based aspects of global and Indian large-scale CHW programs as well as the performance of the Accredited Social Health Activist (ASHA) program.

INDIAN CHW PROGRAMS: EVOLUTION AND IMPLICATIONS

CHW programs in not-for-profit organizations

Several CHW programs have been undertaken by the not-for-profit/voluntary health care sector across the country since the 1950s.[4] In fact, these organizations have played a definitive role in introducing and shaping the role of female CHWs in health care. Two prominent CHW programs exemplify this.

The first example is that of the CHW program started by the Comprehensive Rural Health Project (CRHP)[5] which is located in one of the 250 most deprived districts of India called Jamkhed.[6] It was first initiated in 1970, by Drs Rajnikant and Mabel Arole. They selected, trained, monitored and supported local women with minimal education to work as Village Health Workers (VHWs). The VHW model of CRHP paved the way to strengthen the CHW programs in the country. So far, this model of health care has been introduced to 178 countries across the world.

Another well-known example of a CHW program is by an organization called SEARCH, working since 1985.[7] It is based in Gadchiroli, a tribal district which is also among the 250 most deprived districts of India.[6] The notable successes of the CHWs of SEARCH include improvements in home-based neonatal care[8] and early identification of neonates at risk of pneumonia.[9] SEARCH continues to demonstrate the immense potential of CHWs to achieve the goals of health care systems.

These are just two known examples from one state of the country, Maharashtra, but India has several CHW programs in the voluntary sector. The experience and expertise of the not-for-profit organizations has also been beneficial for the planning, training and monitoring of the CHW programs in the government's public health services.

CHW programs of the Indian government (1940–2005)

Most of the Indian population lives in villages. Due to the varied topography, distance from health facilities, and uneven quality of public infrastructure, poor accessibility of government public health services is an ever present challenge.

Some of the earliest proposals to include CHWs in the public health care services were made before India became independent of British rule in 1947. These were in the form of the recommendations for the government made by the Sokhey Committee in 1940 and the Bhore Committee in 1943. However, these early attempts were not successful as the recommendations of both the Committees were not taken forward by the administration of those times. CHW programs in the form of the basic health workers for malaria control and family planning were not formally initiated by the government until the 1960s (Box 1).

Two national CHW programs of the 1970s

In the 1970s, two national CHW programs (CHW programs covering the villages of the entire nation) were initiated by the government (Box 1). In 1975, a program called the Integrated Child Development Services (ICDS) scheme was initiated for villages with the support of the United Nations Children's Fund (UNICEF) and the World Bank. Two local women from every village were selected, trained, and monitored to provide ante-natal and post-natal care in their own villages (Box 2). They were called the Anganwadi (crudely translated as courtyard) worker and the Anganwadi helper. This CHW program is fully functional to date.

A little later in 1977, another national CHW program called the Swasthya Rakshak Scheme was initiated for villages by the government. This program was meant for providing basic health care at the village level by male CHWs (Box 2). About 400,000 male CHWs called Swasthya Rakshaks (crudely translated as guardians of health) were in position across the states of India within a few years.

Box 1 Community health worker programs of the Indian government (1940–2006).

Year	Community health worker program
1940	The Sokhey Committee recommended workers for basic health care in villages, but this was not implemented.
1943	The Bhore Committee recommended health visitors in rural schemes, but this was not implemented.
1963	The Chadha Committee was set up for national malaria eradication. Its recommendation of basic health workers at the ratio of one CHW per 10,000 population to work as multi-purpose workers to work for basic health care was accepted.
1975	The Integrated Child Development Services Scheme began. One Anganwadi worker and helper each were appointed per village to provide a package of nutrition, preschool education, and health services to children under the age of 6 years. It continues to date.
1977	A national CHW scheme for villages called the Swasthya Rakshak was initiated. The scheme dwindled to a halt.
1978	The Declaration of the Alma Ata
1990 onward	Several state-level CHW schemes but no national scheme
2006 onward	A national CHW Scheme called the Accredited Social Health Activist (ASHA) scheme introduced under the National Rural Health Mission (2005–2012).

Source: National Health Systems Research Center (NHSRC)[10] and Committees and Commissions.[11]

Box 2 Responsibilities of the Anganwadi workers and the Swasthya Rakshaks.

Responsibilities of the Anganwadi Workers

To provide a comprehensive package of health care and development for every child from 0 to 6 years of age in the village. The Anganwadi workers have 21 duties covering health, nutrition, preschool education, home visits, record keeping, and assistance to the government's primary health centers.

Responsibilities of the Swasthya Rakshaks

To provide basic curative, preventive, and promotive health care at the doorsteps of people's homes. To involve rural people in the monitoring and control of basic health services.

Source: UNICEF[12] and Eighth report of Committee on Empowerment of Women (2011–2012) 15th Lok Sabha.[13]

The services of the Swasthya Rakshak, the Anganwadi worker and the Anganwadi helper together, could have provided the entire gamut of primary health care to villages and strengthened the community's linkages with the government's health services. However, while the Anganwadi program continued and expanded, the Swasthya Rakshak scheme dwindled to a halt in just a few years.

Several reasons were attributed for the discontinuation of the scheme, including lack of political commitment, resistance from the bureaucracy, administrative lapses, poor resource allocation, and lack of cooperation from the doctors and nurses.[14,15] The situation was compounded by the fact that the scheme was implemented differently within each state of the country, albeit with common support from the central government.

At the heart of the discontinuation, however, was the resistance of the program administration to the organized protests of the CHWs in this scheme. At the outset, the CHWs or Swasthya Rakshaks were all men. Later, due to the growing importance of maternal and child care, the government began to phase out the men and recruit women as CHWs. The male CHWs unionized and litigated against their own removal.[14] An atmosphere of negotiation was not evident as seen from the manner in which the scheme was soon closed down. Although there was no formal closure due to the sensitive political ramifications, the Swasthya Rakshak scheme was deprived of official support and finances until it dwindled to a halt.[14,15] It is significant that the reaction of the political leadership and the bureaucracy of the times was one of resistance toward the CHWs' agitation for their rights.

The Anganwadi scheme with female CHWs providing maternal and child care continues to function in the country. In due course, the Anganwadi workers also formed unions, demanding increases in their fixed payments and reforms in other service conditions. In contrast to the preceding scheme, their services were not discontinued, however, reforms in their service conditions have not been speedy. After decades of organized protests, the Anganwadi workers now receive paid maternity leave, medical insurance, and a raise in their fixed payments. The progress has been uneven in different states. Some workers and activists have litigated further for better remuneration. Recently, the high court ordered for a raise in the payments of the Anganwadi workers and helpers in one state.[16]

Progression of national CHW programs in India from the 1970s to 2005

After the 1970s, while the Anganwadi scheme for maternal and child care was continued, there were no further efforts to re-launch a national CHW

program for basic health care in India to replace the scrapped Swasthya Rakshak scheme. Such programs were only introduced by some states in the country (Box 1). Significantly, almost all these programs had female CHWs.

It was only in 2006 that a new national CHW program for basic health care was introduced in the country. This was the ASHA program, which had female CHWs known as ASHAs.

The ASHA program (2006 onward)

From the year 2005, India implemented the National Rural Health Mission (NRHM). The NRHM is a comprehensive and broad-based health care plan by the government for the rural and tribal populations of the country. This initiative has now been extended to urban areas as well and is called the National Health Mission.[17]

The NRHM provides access to improved health care at the household level in villages through a school-educated local female CHW called the ASHA. She is selected, trained, monitored and given fixed performance-based incentives per task by the government. So far, the ASHA program has been successful in terms of increasing the rate of institutionalized deliveries overcoming service barriers. The ASHA program has attained roughly 70% coverage of both mothers and neonates in participating areas. It has also been successful in the facilitation of the treatment of illness episodes at government facilities.[18]

The responsibilities of these CHWs have been increased along with their training modules, and a program for the home-based care of newborns has now been added to their responsibilities. However, apart from the successful launch and continuation of this program,there is also a change in the approach of the stakeholders towards the rights of the CHWs of the program.

The key features of the ASHA (loosely translated as hope) program demonstrate that the perspectives of the stakeholders regarding the rights of CHWs have evolved since the 1970s. The voluntary health sector has played a major role in this evolution.

Key features of the ASHA program

Three key features of the ASHA program demonstrate the evolution of the rights perspective for CHWs. The first key feature is the transparency in administration of the ASHA program. Experienced members from the voluntary sector have been involved from the planning stage and have also created the training modules. The members of the ASHA monitoring committees at the national and state levels are drawn from the voluntary sector and from academia, loosening the monopoly of the bureaucrats over governance and enhancing the visibility of the rights of ASHAs.

Second, the ASHA program is evaluated regularly by the government for its performance through various external academic institutions and experts from. Third, local voluntary organizations in some states are encouraged to set up community monitoring systems at the village level.

The fourth aspect of transparency is that a lot of information about the program including the minutes of official meetings and evaluation studies has been made available in the public domain. This transparency was not present in the earlier CHW programs and ensures that civil society has access to program developments.

The second rights-friendly key feature of the ASHA program is that the program is designed around the skill development of the CHWs. For instance, detailed guidelines for the ASHA program were prepared jointly at the outset by all the stakeholders (Box 3). Successive training modules have been also designed to increase the scope of the ASHAs' work. They were released by the central government and are currently implemented by 31 states and union territories of the country. The states are free to innovate within the program and have done so. For example, the state of Punjab has empowered the ASHA as a resource person for cancer detection and the state of Kerala for fighting gender-based violence.[19] Thus, the potential of these CHWs is recognized and the growth aspirations of the ASHAs are addressed.

Just a few years into the program, however, the ASHAs' dissatisfaction with their performance-based payments has emerged as one of the prominent difficulties of the ASHA program. Many ASHAs have formed unions and agitate regularly for a basic fixed amount besides salary; and for better governance.[14] The responses of the stakeholders to the ASHAs however, are very different now three decades after the closure of the Swasthya Rakshak scheme, where the workers largely struggled alone for their rights, with the support of some health activists and left leaning political parties. The response of the administration to their difficulties was limited. In contrast, today, there is a new readiness to discuss the gaps in the service conditions of the ASHAs at several platforms. This is the third key feature of the ASHA program and the one that is the most reflective of the progress gained in CHW programs in India with regard to the rights of CHWs. Civil society has played an important role in this new openness.

Advocacy efforts by the civil society

Academia and civil society have made several advocacy efforts. Research findings have been submitted to the government that have reported the inadequacy and irregularity of ASHA payments,[10,20,21] the lengthy and complex processes for claiming payment,[20] the pressures faced at home and work by the ASHAs,[14] and the importance of training and adequate remuneration for motivating them.[22]

At the outset of India's 16th parliamentary election in the month of April 2014, health experts have advocated for better service conditions for health workers, among other recommendations for the new

Box 3 Guidelines for the Accredited Social Health Activists (ASHA) program.

About ASHA

One of the key components of the National Rural Health Mission is to provide every village in India with a trained female community health activist ASHA or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system. Following are the key components of ASHA:

- ASHA must primarily be a female resident of the village, preferably in the age group of 25–45 years.
- She should be a literate woman with formal education up to class 8. This may be relaxed only if no suitable person with this qualification is available.
- ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal officer, the village Health Committee, and the Gram Sabha.
- Capacity building of ASHA is being seen as a continuous process. ASHA will have to undergo a series of training episodes to acquire the necessary knowledge, skills, and confidence for performing her roles.
- The ASHAs will receive performance-based incentives for promoting universal immunization, referral, and escort services for Reproductive and Child Health (RCH) and other health care programs, and encouraging construction of household toilets.
- Empowered with knowledge and a drug-kit to deliver first-contact health care, every ASHA is expected to be a fountainhead of community participation in public health programs in her village.
- ASHA will be the first port of call for any health-related demands of deprived sections of the population, especially women and children, who find it difficult to access health services.
- ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community toward local health planning and increased utilization and accountability of the existing health services.
- She would be a promoter of good health practices and will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.
- ASHA will provide information to the community on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services, and the need for timely utilization of health and family welfare services.
- She will counsel women on birth preparedness, importance of safe delivery, breast-feeding and complementary feeding, immunization, contraception, and prevention of common infections including reproductive tract infection/sexually transmitted infections and care of the young child.
- ASHA will mobilize the community and facilitate them in accessing health and health-related services available at the Anganwadi/sub-center/primary health centers, such as immunization, ante-natal check-up, post-natal check-up, supplementary nutrition, sanitation, and other services being provided by the government.
- She will act as a depot holder for essential provisions being made available to all habitations like oral rehydration therapy, iron folic acid tablet, chloroquine, disposable delivery kits, oral pills and condoms.
- At the village level, it is recognized that ASHA cannot function without adequate institutional support. Women's committees (like self-help groups or women's health committees), the village health and sanitation committee of the Gram Panchayat,[a] peripheral health workers especially auxiliary nurse midwives (ANMs) and Anganwadi workers, and the trainers of ASHA and in-service periodic training would be a major source of support to ASHA.

Source: National Health Mission.[17]
[a]Gram Panchayat is the village level self-governing body that channels the government's programs.

government, regardless of its political affiliation.[23] The remuneration of the ASHAs has been raised in the annual monitoring meetings of the civil society.[24] Even mainstream newspapers have advocated for better payments for ASHAs.[25]

The difficulties of ASHAs have thus already gained visibility in the early years of this program. In the past few years, the rights of the CHWs in the ASHA program and earlier government programs have also been acknowledged by the government as seen in the discussion below.

The evolution of a rights-based perspective within the government

There are more than 1.33 million Anganwadi workers, 1.15 million Anganwadi helpers, 2.74 million cooks for mid-day meals for children[26] and 0.87 million ASHAs[19] in India today. They are all women, and all working for the government's CHW programs. The stakeholders at various government platforms in the recent years have highlighted the gaps in the service conditions of these CHWs.

The draft 12th Five Year Plan (Government of India, 2012–2017) mentions that there are gaps in the training and payment of timely incentives in the ASHA program.[27] Members of the Mission Steering Group of the National Health Mission held under the Chairmanship of the Union Minister of Health and Family Welfare have raised their concerns about the adequacy and timeliness of incentives for ASHAs and other honorary workers in the government.[24] However, no consensus has been arrived at since the powers for reforms are vested with both the central and the state governments.

A recent government report on the empowerment of women has presented its findings on the working conditions of Anganwadi workers. It calls attention to the government's efforts to improve their service conditions by providing for increasing payment, growth avenues, retirement benefits, insurance, and providing maternity leave.[13] However, it also records that there are no standard procedures for revision of their honorariums since the Anganwadi workers do not do all their tasks daily. Second, the program design leaves the implementation of these service conditions to the state governments.

The working conditions were also highlighted at the eighth annual conference of the Ministry of Labour and Employment of the Government of India,[26] which called attention to the service conditions of Anganwadi workers, helpers, community cooks and ASHAs. These workers were termed as belonging to the unorganized sector, although working for the government. These are unprecedented rights-based statements on a government platform. However, despite growing visibility, the relevant policy reforms to address the rights of the CHWs are yet to be formulated by the government due to several factors.

Hindrances to policy reforms: lessons for similar programs

The factors that hinder relevant policy reforms for the CHWs working in national CHW programs of India are relevant for other CHWs placed in similar settings. One basic common attribute among CHWs worldwide is their designation as volunteers. India is home to a very large number of female CHWs and helpers working for the government. Since they are not full-time workers, they are currently designated as 'honorary workers'. This designation is seen as a limitation for setting any standard service conditions for them by the government.[13] It also reduces the CHWs' power to negotiate for their rights.

Another basic common attribute of most CHWs is the flexibility of their daily tasks and working hours. In the case of the ASHAs and Anganwadi workers, this is an asset to the health services due to their ready availability to the community at all hours. However, the flexibility is disadvantageous to any standard appraisal of their working hours or tasks. This hinders any reforms in their service conditions.[13,24]

Thus, the two hallmark characteristics of most CHWs, namely, their designation as a voluntary worker and the flexibility of their tasks and timings, can be detrimental to their rights. Some experts might argue that setting norms for tasks and timings defeats the entire concept of engaging with CHWs. However, the CHW concept is now tried and tested. Standardization could be the best way forward in the interest of both the CHW and large programs with fixed agendas.

The dissatisfaction of ASHAs and their consistent demand for a stable monthly payment indicates that performance-based payments do not offer the desired financial security and can demoralize CHWs in poor communities.[28] However, the national CHW programs preceding the ASHA program did offer fixed payments, yet there was dissatisfaction over the amounts of remuneration. This indicates that CHWs in Indian national programs look toward their post as a source of income. They also feel justified to organize and raise demands over rights as these programs are run by the government.[28]

The modes of governance are another factor hindering reforms in India. National CHW programs are introduced by central government but are implemented by the states. Decentralization ensures that several levels of administration are involved in administering the program. One of the consequences impacting the CHWs is that there are lengthy processes involved in claiming payments and further delays in releasing the payments.[28] The onus of making changes is often passed by the central bodies to the state-level administration.[13] However, the same administrative system seldom delays the payments of the full-time employees, thus raising a question on the commitment of the governing bodies toward CHWs, who are volunteers.

Thus, the volunteer designation, the flexibility of their tasks and timings, and modes of governance are three prime hindrances to service reforms in the ASHA and Anganwadi programs. This trend is seen in other countries as well. In most countries, CHWs have never been integrated into the established, salaried team of health system workers.[29]

CONCLUSION

There is a growing acknowledgment of the rights of the CHWs within the ASHA and Anganwadi programs, but like CHWs worldwide they are largely deprived of standard service conditions. The roots of this widespread practice lie in the expectation that the lowest rung of the health services should work in the spirit of community service. This deprives CHWs of their rights as workers. Where these CHWs are women, caring for the health of their own community is often seen as an extension of their nurturing role within their families. This is a gender issue that is easily overlooked. Such values do not fit into the current realities of the CHWs' lives.

There is a need to redefine the basic characteristics of CHWs and to delineate their designations, tasks and timings, in order to protect their rights in large-scale programs. When the CHWs are in national programs, they facilitate the government's health programs. Therefore, they are legally entitled to standard service conditions, and the modes of governance need to be changed to facilitate their incorporation as fully-fledged members of the public health team.

Any proposal to re-designate CHWs as employees can give rise to several objections in terms of the motivation, efficiency, costs, and quality control. The integration of CHWs as full-fledged members of the health system and not as peripheral participants will have to be a gradual process. Rigorous performance assessment, identification of a basic skill set, training, supervision, and infrastructural support will be required. More importantly, it will require a change in the attitude of the administration, toward taking full

ownership of the CHW programs. The perils and the benefits of undertaking or neglecting this responsibility must be evaluated by all countries that have undertaken large-scale CHW programs.

CONFLICT OF INTEREST

The views expressed in the submitted article are my own and not in an official position of any institution or funder.

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