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SPECIAL EDITORIAL

The Contemporary Rights-based Debate on Community Health Workers

An Analytical Perspective from India

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In September 1978, India was one of the signatories of the Declaration of the Alma Ata that aimed for “Health for All by 2000 A.D.” This Declaration placed health care among other determinants of health, thus contextualizing curative care with preventive and promotive health care. It asked countries to commit for education, sanitation, nutrition, water supply, maternal and child health and curative care for all (WHO, 1978).

Community Health Workers as seen by Alma Ata

The transfer of information and interventions from health professionals to the general public was envisaged as an integral part of health care. The involvement of Community Health Workers (CHWs) or village health workers as they were then called, was given due importance in health care. It originated from an understanding of people-centered health, where the community itself was seen as a resource in its own health care. The Alma Ata vision also saw CHWs not as belonging to isolated programmes, but as a part of a structured health care work

force. However, there was no elaboration of the structure of the health care force.

CHWs as seen by WHO in 2018

In 2018, a declaration on Primary Health Care was placed in the public domain by WHO at Liverpool. For the first time, the WHO articulated a rights perspective with regard to the health care work force.

Human Resources for Health

We will create decent work and appropriate compensation for health professionals and other health personnel working at the primary health care level to respond effectively to people's health needs in a multidisciplinary context. We will continue to invest in the education, training, recruitment, development, motivation and retention of the PHC workforce, with an appropriate skill mix. We will strive for the retention and availability of the PHC workforce in rural, remote and less developed areas (WHO, 2018a: 8).

A direct suggestion for countries such as India emerged in the CHW Guidelines, a separate document issued by the WHO at Astana (formerly Alma Ata) on the fortieth anniversary of the Alma Ata Declaration. A lengthy document elaborating every aspect of CHW programmes like selection, training and working conditions, it does not shy away from giving recommendations for payments as well. At the same time, there was also an indication by the WHO, that there was weak evidence to support their payment suggestions, indicating the paucity of adequate research in the area of rights for CHWs.

WHO suggests not paying CHWs exclusively or predominantly according to performance-based incentives (WHO, 2018b: 15).

Current Scenario of CHWs in India

Let us pause and reflect where India stands vis-à-vis the directions indicated by the WHO. The public health care services of India extends to every village and slum today due to the presence of the largest global woman workforce of CHWs. Under the Integrated Child Development Scheme, there are 2.7 million Anganwadi Workers and Anganwadi Helpers. Under the Accredited Social Health Activist programme, there are 0.87 million rural Accredited Social Health Activists (ASHA) and along with their counterparts the Urban Social Health Activists (USHA) working in slums, they would add up to another one million CHWs. There are 2.8 million Midday Meal Workers.

Of these, the ASHA programme with their structured training modules, has grown at a phenomenal pace since it began in 2005. These CHWs extend maternal and child health services, nutrition, education and a host of primary healthcare services to the poor. In the fast changing scenario of the Indian public health care services today, new programmes are constantly being added, and these village women are given new tasks regularly.

This entire CHW woman workforce is trained by the local full time health workers of the government in conjunction with the civil society. These frontline workers are placed within a three tier health care structure, from 5,000 to 20,000/30,000 to 1,00,000 population levels in the rural areas. Their urban counterparts working in slums are placed in a sparser public health setting with dispensaries, urban health posts and hospitals.

These CHWs are supervised by full time public health employees. There are women ASHA Facilitators, male Multi-Purpose Workers, Health Assistants, and some other vertical programme workers at the community level. There are around 19 million Auxiliary Nurse Midwives (ANMs) and Lady Health Visitors (LHVs) at the community level. At all the levels of the three tier facilities, in varying proportions, there is a fulltime workforce of doctors, nurses, technicians like pathologists/ pharmacists and the administrative and support staff. There are ambulance services with dedicated helplines available. Public-private partnership is seen in various models of health insurance programmes.

That the country consistently maintains and runs such a vast public health workforce for decades is notable, despite the very real fact that the quality of health services is uneven across the vast geographical stretch of India. The selection, training and supervision of a still expanding number of women CHWs, each working from their own village, is another notable achievement in itself.

Impact of India's CHWs

When the CHW workforce is so large, then comes the question of the impact of their work upon the health care of the population that they are designated to serve. It is often said that the public health services are limited in scope, as 75 percent of the total healthcare services available in India, are in the vastly unregulated private sector. It is time to revisit this overused statement.

While it is true that curative care is largely in the domain of the private healthcare sector, there are sections of the tribal and poor, the women and the children, that get their curative care from the public health services too. It is also a fact that the preventive and promotive health services in the villages and slums are almost completely handled by the public health care services system. This is made possible by the frontline workers backed by the graded health care services. Although a lot remains to be done, significant strides have been made in controlling infant and maternal mortality and in disease control.

Place of CHWs in India's Public Health Care Services

Despite these very real advancements, Indian CHW programmes are limited in their scope of operations, as they do not have a permanent place within the public health care services system. All the CHW cadres are designated as volunteers and paid incentives. Being a federal government, the Centre-State share in the incentives varies, as each state can decide or forego their own contribution to the basic Central government incentive. In 2018, the Prime Minister had announced a new raise in ASHA incentives from the Central government. However, the amount is still small, as the total Central government base incentives for the ASHAs today add up to around Rs. 2,000/- month (USD 30) and of Anganwadi workers around Rs. 3,500/- month (USD 50). In addition, ASHA workers get varying amounts as task-based incentives from state level allocations in some states.

The recent official announcement by the Central government also granted life insurance coverage and accident coverage for ASHAs. This is welcome, but medical insurance would have been more appropriate and useful. To the best knowledge, Anganwadi workers have no such coverage.

Some states do recognise the efforts of both these categories of CHWs by way of "Best worker" announcements. Apart from these, there are no benefits. Medical insurance coverage, retirement benefit or stable career advancement ladder have been suggested from several quarters.

Hierarchy-Informalisation-Gender

Three interrelated and underlying factors are accountable for the denial of important workers' rights for India's CHWs. These are the triumvirate of Hierarchy-Informalisation-Gender. Their impact is manifested in numerous ways, which are worthy of some elaboration.

Health care services are normally hierarchical structures, and to top that, the Indian public health services originate from services for British

military camps. While running such a massive infrastructure today would require systems and processes, we also seem to have inculcated the culture of hierarchy and deference to authority of the military forces, on pain of punishment. It is not surprising that the foot soldiers/CHWs bear the brunt of authoritarianism. We also see unofficial “task-shifting” at local levels, and a general lack of regard for the work of CHWs, who are in no position to complain, being volunteers.

The voluntary status of CHWs is best seen within the larger context of the structure of the public health care services system. While India has a stable and permanent public health care workforce, there has been a large scale expansion of the work force under the National Health Mission (NHM) since the past two decades. An additional layer has been added to the permanent cadres by way of contracted workers. All the workforce of NHM, from doctors and nurses to technicians and administrative positions, are under renewable contract.

Living with lesser wages and no job security, these workers are a part of the informalisation process, along with the CHWs. Their associations demand for regularisation of their services, while the government faces human power shortages. Thus the informalisation of the health care services starts right from the fact that the entire NHM workforce is under contract, leaving scarce scope for CHWs to be a part of the formal health care structure. The gender bias in this situation can be seen in the fact that these CHWs are all women. Living and working in a patriarchal society, with inherent safety concerns, they are rendered more vulnerable due to the lack of fair working wages and complete social security.

Where are the answers?

There are few avenues to address the creation of space for CHWs. The trade union movement and CHW associations focus largely on getting better payments. Incentives have risen over the years, but in an erratic fashion, as incentives to volunteers need not adhere to any labour laws or the minimum wages norms.

The civil society is largely pre-occupied in the health care rights of the community, and not the rights of CHWs, with a few notable exceptions. Large sections of the civil society are skeptical about the relevance of such large CHW forces, in the face of the overwhelming presence of privatisation and informalisation of the public health care services. The community too is generally the recipients of their services and not champions for their well-being.

Adding to the complexity of their situation as CHWs, is the recently announced health insurance programme Ayushman Bharat, where the government subsidises hospitalisation for urban and rural poor that meet a pre-decided income criteria in empaneled hospitals. Alternatively hailed as progressive or as encouraging privatisation, it leaves CHWs in a confused situation.

On the one hand, all the primary health functions like nutrition, maternal and child health, prevention of communicable diseases and family planning are with the government and these are directly within the domain of CHWs. CHWs are being given an increasing number of tasks under increasing programmes, including cash benefits for safe delivery. On the other hand, while there are commitments to improve the working conditions, these are yet to materialise. CHWs are roped in to identify potential beneficiaries for public and insurance programmes, while not being entitled to any such benefit themselves. And yet, there is some gendered policy reform when residential trainings were initiated to build empowering knowledge and facilitate ASHA solidarity. ASHAs were also designated as secretaries of their village health committees.

A Direction for the Future?

The WHO vision of frontline workers was one where they would be a part of a stable and structured health care work force. Health care itself was part of a broader vision of the social determinants of health. To meet this vision, reforms and investments in the human resources for health aiming towards stability, regulation of the private sector, and far more investments in nutrition, water supply and education are required. India has a unique and large scale sanitation programme that must be up-scaled qualitatively.

Reforms and expansions in medical and nursing education are needed, but there need to also be planned avenues for more women, social scientists, psychologists and communication experts in public health care. CHWs will get their due place only when health is seen as quality of life and not as delivery of services led by medical professionals. And, when women are at the forefront, when hierarchy is not all important in health care.

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