WORKING PAPER

People's Health in People's Hands?

A review of debates and experiences in community health in India

Harsh Mander

This paper will attempt to review briefly the history and debates in India around community health workers and their roles and relevance to more equitable and effective public health systems and services. It will engage with debates around diverse practices in the design and implementation of CHW programmes, both in non-government micro-experiments, usually covering a small cluster of contiguous villages, and larger state-led programmes, covering the countryside in entire states or the nation as a whole. It concludes with recommendations for critical aspects of the design and implementation of CHW programmes. This review is restricted to rural health, although it is important to apply these lessons and debates to urban health care, especially for the underserved and dispossessed residents of shanties and streets in all cities and towns.

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Harsh Mander

Abbreviations:

WHO	**World Health Organisation**
JSR	**Jan Swasthya Rakshak**
RUHSA	**Rural Health And Social Action**
CHW	**Community Health Worker**
ASHA	**Accredited Social Health Activists**
TNSF	**Tamil Nadu Science Forum**
NIHFW	**National Institute of Health And Family Welfare**
NRHM	**National Rural Health Mission**
PHC	**Primary Health Centre**
CHC	**Community Health Centre**
ICDS	**Integrated Child Development Scheme**
ANM	**Auxiliary Nurse Midwife**
AWW	***Anganwadi* Worker**
CEHAT	**Centre For Inquiry into Health and Allied Themes**
VHW	**Village Health Worker**
SHG	**Self Help Group**
PRI	**Panchayati Raj Institutions**
MP	**Madhya Pradesh**
CEDPA	**Centre for Development and Population Activities**

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Inspired by remarkable local initiatives to mobilise, train, deploy and support lay volunteers as community health workers, there has long been an influential segment of opinion among public health administrators, practitioners, activists and researchers, in support of community based approaches to public health. Central to most of these approaches are some variety of community health workers (henceforth referred to as CHWs), widely (but not universally) regarded as potentially the most immediate, effective and direct link between people and public health institutions, practitioners and services.

This paper will attempt to review briefly the history and debates in India around CHWs and their roles and relevance to more equitable and effective public health systems and services. The paper will also try to capture debates around diverse practices in the design and implementation of CHW programmes, both in non-government micro-experiments, usually covering a small cluster of contiguous villages, and larger state-led programmes, covering the countryside in entire states or the nation as a whole. The paper will try not to be prescriptive, but will still conclude briefly with the author's recommendations about preferred approaches around many critical aspects of the design and implementation of CHW programmes. This review will restrict itself to rural health, although it is important to apply these lessons and debates to urban health care, especially for the underserved and dispossessed residents of shanties and streets in all cities and towns.

BRIEF HISTORY OF CHW PROGRAMMES IN INDIA

A widely accepted definition of the CHW, developed by a WHO Study Group, is that "community health workers should be members of the community where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by health system but not necessarily a part of its organisation, and have shorter training than professional workers". (Kahssay, et al, 1998: 4).

The merit of the definition is that it firstly emphasises that the CHWs should be residents of the communities that they serve and should be primarily accountable to them; and that they should be supported by the public health system, but not be part of it. The only amendment that I would suggest to

this definition of the CHW would be to add some reference to the mandatory primacy in her duties of preventive and promotional health planning and services, with a subsidiary component of first contact curative care. It is important also to recognise that the CHW is not an isolated worker and provider, but is necessarily located within community institutions and processes. It is therefore preferable to speak of community health services, of which the CHW is a key component and facilitator, rather than of the CHW as though she is an autonomous and independent agent.

In India, as early as in 1940, Nehru chaired a Planning Committee of the Indian National Congress, which recommended the training of one health worker for every 1000 people within 5 years (Ashish Bose, 1983). Gandhi too envisaged village doctors in the 1940s, and even planned to start a training programme at Wardha before his assassination (Astekar, 2002). He was remarkably prescient about the paramount significance of preventive and promotional health care as compared to curative care[1].

These perspectives were virtually lost in the initial decades after Independence - in the glitter of a health care model that was dominated by high cost, mostly urban, professionalised and institutionalised curative services - or in other words, by doctors and hospitals located mainly in towns and cities.

A major turning point in public health policy in India came in 1975, through the landmark official 'Report of the Group on Medical Education and Support Manpower' popularly known as the Srivastava Committee. It identified and acknowledged the following problems in medical education and health services:

- The essentially urban orientation of medical education in India, which relies heavily on curative methods and sophisticated diagnostics aids, with little emphasis on the preventive and promotional aspects of community health,
- The failure of the programmes of training of medical practitioners in the fields of nutrition, family welfare, and maternal and child health, and
- The deprivation of the rural communities of doctors, in spite of the increase of their total stock in the society (Srivastava Committee Report, 1975: 261).

The first major point of departure of the Srivastava Committee was to recognise that public health is critically linked to the socio-economic conditions of people. It observed unambiguously that a universal

[1] He writes in *Harijan,* 'Doctors aver that 99% of disease springs from insanitation, from eating the wrong food, and from under-nourishment. If we can teach this 99% the art of living, we can afford to forget the 1%...' (Harijan, 1-9-1946, 286).

and egalitarian programme of efficient and effective health services cannot be developed against the background of a socio-economic structure in which the largest masses of people still live below the poverty line. There is, therefore, no alternative to making a direct, sustained and vigorous attack on the problems of mass poverty and for the creation of a more egalitarian society. A nation-wide programme of health services should be developed side by side with this larger battle on poverty, as it will support this major national endeavor and be supported by it in turn.

It goes on to radically suggest that there has been an undue emphasis on the curative aspects of public health, which are probably the least important. It maintains that the State has an overall and supreme responsibility for providing a comprehensive and nationwide network of health services. This includes a direct attack on mass poverty; provision of adequate nutrition; development of integrated services in education and health; and the organisation of para-professional and professional service to cover the promotive, preventive and curative aspects, with emphasis on maternal and child health services which are of the highest priority in this country.

The report is highly significant because for the first time it explicitly spells out the critical need for a CHW, to correct what it describes as the over-emphasis on provision of health services through professional staff under state control, which has been counter productive. Its lucid description of the profile and mandate of CHWs can hardly be improved ever today. "What we need therefore, is the creation of large bands of part-time semi professional workers from among the community itself who would be close to the people, live with them, and in addition to promotive and preventive health services including those related to family planning, will also provide basic medical services needed in day-to-day common illnesses which account for about eighty per cent of all illness" (ibid: 266).

It stresses that the CHW should not supplant or compete in any way with the formal health system, but should supplement it. It lays great emphasis on creating a professional, highly competent, dedicated, readily accessible, and almost ubiquitous referral service to deal with complicated cases that need specialised treatment.

It perceives this proposed shift of focus to communities, as carrying the potential to democratise health services. It points out that in the existing system, the entire programme of health services has been built up with the metropolitan and capital cities as centers, and tries to spread itself out in the rural areas through intermediate institutions such as Regional, District or Rural Hospitals and Primary Health Centres and its sub centres. Very naturally, the quantum and quality of the services in this model are at their best in the Centre, gradually diminish in intensity as one moves away from it, and admittedly fail or are highly diluted

at what is commonly described as the periphery. Unfortunately, the 'periphery' comprises about 80 per cent of the people of India, who should really be the focus of all the welfare and developmental efforts of the State. "It is, therefore, urgent that this process is reversed and the programme of national health services is built with the community itself as the central focus. This implies the creation of the needed health services within the community by utilising all local resources available, and then to supplement them through a referral service which will gradually rise to the metropolitan of capital cities for dealing with, more and more complicated cases" (ibid: 266-67).

The Srivastava Committee of 1975 was a forerunner for a similar advance in the theory and practice of public health at the international level as well. In 1978, the path-breaking conference on Primary Health Care in Alma Ata advocated the CHW as a central agency to advance primary health care. It called for the creation of national level CHW programmes to be able to serve unreached populations, especially village communities and their unmet health needs, whether preventive, promotional or curative. In subsequent decades many countries in Africa, Asia and Latin America have major official CHW programmes. CHWs have been a core element (Kahssay et al, 1998).

Internationally, a number of empirical studies of CHW programmes have shown that "they can effect major changes in mortality and other indices of health status and that in certain communities they can satisfy prominent health care needs which cannot realistically be met by other means" (Kahssay, et al, 1998: 1). In a definitive survey of CHWs in many countries, Frankel (1992) confirms the enormous potential of CHWs to meet the health needs of underserved populations, but also establishes that many programmes have floundered on the bedrock of unimaginative design and lack of professional will and support.

It is these failures that have tended to dog most past official forays in India into CHW programmes, although India also has been home to several highly successful non-governmental micro-experiments. Taking many leads from the Srivastava Committee, 1975, the Indian government in 1977 introduced a nation-wide programme of CHWs, envisaged even at that time primarily as a critical bridge between communities and organized health services. The government aimed at providing "adequate medical care where such care where such care is needed, and to educate the people in the matter of preventive and promotive health" (Kumar et al, 1983: 17). The CHW was envisaged as a catalytic change agent to assist communities to realise "that the health status of the rural population can be improved not merely by increasing the numbers of doctors or increasing the output of medicines, but by making each individual realize and appreciate the need of simple steps in sanitation, preventive, promotive and rehabilitative health activities" (ibid: 17).

The village communities would select these CHWs for every 1000 people, training would be by the local PHC, a monthly stipend paid and a drug kit given for part-time curative care services. There was stress on health education and immunisation, and integration with traditional systems of medicine.

This scheme was introduced during a turbulent phase of continuing political upheaval in India, and it also the bore the brunt of this climate of uncertainty. The scheme suffered repeated changes in nomenclature, allocations, and political commitment – as well as influential resistance and mockery from the medical establishment. Reviews have also indicated numerous design flaws and failure of implementation, to which we will return to in subsequent sections.

The scheme collapsed under the weight of its many contradictions and weaknesses by the mid 1980s. Its demise was largely un-mourned, but with the benefit of hindsight, today we should posthumously acknowledge its path-breaking character. Ashish Bose (1983) regards "as the main achievement of the CHW programme" that it was "the first serious attempt by the government to delink the CHW from the medical bureaucracy. This was an important political step. Not being a government employee, the CHW could not be dismissed by the government Medical Officer. This relationship symbolized the supremacy of the community (represented by the village council) over the medical bureaucracy… The Scheme directly benefited women, children and weaker sections of the community (Harijans and backward castes) by providing greater access to curative care from the CHW and through referrals to higher levels of health care. To some extent the Scheme also made village communities more aware of the need for disease-preventive measures such as environmental sanitation. It also informed and educated some communities to demand better government health services as a right, rather than passively accepting the inadequate services provided. CHWs often proved to be a useful link between the health authorities and the community" (Bose, 1983: 43-44).

The scheme was therefore undoubtedly a significant milestone in the country's journey towards more equitable public health services, and of enabling people to take their health into their own hands. Decades later, state governments like those of Madhya Pradesh and Chattisgarh also introduced ambitious state-wide CHW programmes. In 2004, Government of India announced a National Rural Health Mission (NRHM) with "a … goal of addressing the health needs of rural population especially vulnerable sections of the society". CHWs (renamed ASHA or Accredited Social Health Activists**)** are being rediscovered and reinvented as one cornerstone of the National Rural Health Mission. The draft paper released by the Government proclaims that 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

(Draft Guideline Note on ASHA, NRHM: 1). In their newest incarnation, CHWs are being envisaged as trained women health workers, who are linked to the Panchayats and supported mainly by the village community. The exact design of the programme is still unfolding at the time of the writing of this paper.

The national government's plan to reintroduce CHWs nationally has once again resurrected many impassioned debates among policy makers and development professionals around the appropriateness and dangers of the CHW approach to public health, and several design issues. This paper will attempt to summarise some of these debates in subsequent sections.

STRENGTHS AND DANGERS: MAJOR DEBATES AROUND CHWS

It is remarkable that the wide and often shrill skepticism and opposition in professional, activist and public policy circles in India that marked the first official CHW programme of 1977 is now largely absent, more than two and half decades later, when the central government has announced its intention to launch a revised and improved nation-wide CHW programme. It is symbolic of a much greater consensus, among many diverse segments of opinion and stakeholders, about the potential value of some form of a CHW programme, to democratise public health, and meet several urgent unmet health needs of unconscionably large segments of excluded and underserved women, men, boys and girls.

However, even among advocates of various versions of the community based public health initiatives, there is wide diversity in their objectives. Many health activists view this as an empowering process of democratising public health, and securing the goal of 'people's health in people's hands'. The underlying conviction is that the overwhelming proportion of people's health problems can be prevented, or even treated, without the intervention or mediation of medical practitioners and curative health institutions. Many see the lay CHW as a vital agency to enable people to access knowledge and plan individual and collective interventions to prevent morbidity and mortality, and to promote better health, particularly among disadvantaged people.

Many impassioned and unresolved debates persist, but these relate mainly to various fundamental design issues - in the functions, selection, training, support and resourcing of CHWs. These debates center on how the potential of CHWs can best be realised, and will be touched upon in later segments of this monograph. However, in this section, we will attempt to summarise the major areas of relative consensus about the strengths of CHWs, and persisting serious concerns about the dangers of the CHW programme.

Evidence to which we will return to repeatedly in this paper, has established the following potential strengths and successes based on the experience, both within India, and elsewhere in the world, of successfully designed, implemented and supported CHW programmes.

(i) The CHW has established herself as a feasible and acceptable link between the public health system and the community.

(ii) She can work as partner both of health professionals and the community, to ensure viable, acceptable, affordable and appropriate primary health care.

(iii) The interventions - preventive, promotional and curative - of CHWs have resulted in demonstrable reductions in morbidity and mortality, particularly of women and children.

(iv) For socially and geographically excluded groups, who typically have large, diverse and urgent health needs, she can herself meet some needs, help individuals and communities deal effectively with other needs, and provide a link to formal public health systems in yet others.

(v) The CHW can help converge appropriate medical technologies from modern and traditional systems of medicine, and also tap and channelise useful local knowledge of effective health practices.

(vi) Many health problems such as those related to nutrition, gender injustice and emotional distress; require individual and family counseling, which the CHW can be equipped to provide in a culturally acceptable and low-cost manner.

(vii) The CHW can help reduce the enormous physical and economic burdens placed on impoverished communities by irrational and inappropriate drug use.

(viii) People's health is closely bound up with a wide range of social, economic, cultural and environmental factors. Formal health systems typically cannot address these more basic and frequently powerful causes of ill health. The CHW can potentially help local communicates comprehend and identify the connections between the health and these diverse factors, and develop plans to address some of these causes, through a variety of means, such as change in individual behavior, collective action, and organised resistance to injustice.

(ix) CHWs may become a vehicle to assist and enable people to plan, manage, and assess health related programmes.

(x) CHWs can assist communities to demand and secure greater accountability from public health systems and programmes. Regular people's audits of health services at various levels can be conceived, based on the informed facilitation of independent CHWs.

Despite wide acknowledgement of this impressive range of potential strengths of the CHW - for promoting a more equitable public health system and meeting people's unmet health needs - there remain several concerns and cautions among health activists about the approach.

The most serious and legitimate fear, that is often voiced, is that the CHW programme may facilitate the back-door gradual withdrawal of the state from investing its resources and personnel in the formal public health sector, in primary, secondary and sometimes even tertiary public health services. They fear that the government is instrumentalising CHWs to provide substitute low-cost (and admittedly low quality) curative care for poor people, because of the manifest and poorly addressed failures of both primary and secondary public health institutions, and the unwillingness of the state to invest sufficient budgetary resources to remedy these failures and gaps. In other words, their concern is that CHW programmes will free the state from democratic mass pressure to invest sufficient resources and attention to the paramount and largely still unmet responsibility of the state to strengthen primary health care. It may condemn impoverished people to low-quality curative health care in perpetuity, in the same way as non-formal education schemes, in effect, reduce the entitlements of vulnerable children to quality mainstream education.

The government may also have an even more limited instrumental attitude to CHWs - as a vital link to secure greater success of vertical health programmes, through extending outreach and strengthening demand, as well as filling gaps in supply. Variations of CHWs have most widely been applied by government to family planning (to the greatest opposition of health activists), but also to RCH, TB, Leprosy, Malaria and HIV AIDS.

The dangers of CHWs being narrowly instrumentalised by the health bureaucracy to facilitate its own abdication from meeting the health needs of impoverished and vulnerable people, and to support its frequently narrow health goals such as terminal contraception, are real. However, these dangers are not intrinsic to the concept of the CHW, and one needs to be alert at the design stage to defend the independent, even activist, character of the CHW.

In would be fatal if the CHW is seen as constituting the lowest rung of the health bureaucracy, the level of functionary that is most disadvantaged in terms of remuneration, training and powers, selected by, reporting to and accountable to the Auxillar Nurse Midwife (ANM) or Anganwadi worker (AWW). Her status must be secured and guarded as that of a community worker, selected by, serving and exclusively accountable to the local community. Part of people's unmet health needs can legitimately be met by individual or collective locally organised and resourced actions. However, some require the state to

intervene, not just in providing referral health services, but also, for instance, in ensuring potable drinking water, social security pensions, functioning of the public distribution system, or running wage employment programmes. In a broad sense, these state responsibilities are to secure the people's right to health. The CHW must have the structural independence, training and aptitude to organise local communities for accessing their health rights.

Another fear voiced by several health professionals, and some activists, is that the CHW programme may legitimise and even encourage quackery. In the first incarnation of the CHW national programme in 1978, the medical profession was united in its implacable opposition to the programme on this ground. Medical practitioners today tend to be much more ambivalent. Whereas there remains some unease about the prospects of 'quackery' of curative care by CHWs, they also see in them an enormous untapped potential for referral services, expanding the markets for their own medical and diagnostic private practice into regions that they are unwilling to service directly. Similarly the pharmaceutical industry has awakened to the potential of CHWs to expand manifold the rural market for the drug industry.

There is also a large body of disinterested support in the literature for 'first contact curative care' by CHWs. Shyam Ashtekar (2002), for instance, lays stress on the need to develop a national curative package for CHWs based on the felt needs of people. He suggests that such a programme would control rather than promote quackery, pointing that even without a CHW programme, "even in the so-called advanced states like Maharashtra, over three-fourths of sickness episodes are served by private medical practioners, the majority of whom know little about illness and medicines they are handling every day". (Astekar, 2002: 429). Trained and regulated CHWs would, according to this view, hopefully supplant the unscrupulous untrained private practioner, the archtypical *'jhola'* doctor dispensing inappropriate injections and saline at usurious fees to a gullible and desperately underserved population.

In a personal communication with me, leading public health activist T. Sundararaman, spoke of the right of every citizen to access to affordable and appropriate curative care. This largely unmet need of significant majorities of rural populations, can be met by CHWs in a variety of ways. Firstly, CHWs can ensure ease of access to curative care. No one should need to travel to more than a kilometer from their home for simple non-regulated drugs like paracetemol, or ORS, iron and folic acid, or deworming tablets etc. A recent survey of illness episodes is Chattisgarh demonstrated that at least 70 per cent of these illness episodes, possibly more, can be adequately dealt with at the hamlet level itself, by a trained and equipped CHW. (SHRC, 2005)

CHWs can also provide protection from the economic and health burdens of irrational cures, and the corruption of private health markets. This is especially high for the common self-limiting illnesses of the upper respiratory tract (the common cold for example) and for diarrhea. As many studies have established, expenditure on private health care constitutes the second highest burden on the meager and threatened incomes of poor rural families second only to food. (George, 1997) "It could have become, (based on preliminary observations that need empirical ratification) the highest source of cash expenditure in many marginalised tribal families in a sustenance economy. Private expenditure on medical services, much of it wasted on irrational and inessential care, is a major cause of indebtedness of poor rural families, which pulls them into the vortex of downward spirals of impoverishment."[2] Anecdotally, Sundararaman spoke of having seen families without food and surviving by eating rats, but with bottles of tonics, prescribed by trained or untrained medical practitioners; families living with chronic hunger are seen to feed their malnourished children diluted Cerelac that had been prescribed to them. "In this way, poorest households in the poorest region of the world are being tricked into contributing revenues to the richest corporations in the richest countries" (ibid).

Trained CHWs may through their first contact, offer curative care services to protect the health of rural populations, and redeem them from the usury of the markets, in the following ways:

- CHWs may enable easy, timely and affordable access to an economical and appropriate mix of modern and traditional systems of cure, including home remedies. Some of these are only symptomatic relief for self-limited illnesses (the common cold or headaches being typical examples). Some are life saving - like the suggestions to keep a low birth weight baby warm, or oral rehydration for diarrhea. Some are common complaints that available sources of advice and treatment handle inadequately, like anemia or white discharge. But all are 'common' and can be addressed through local volunteer-level care, which is almost indistinguishable from what every family ought to know and handle by themselves.
- CHWs may assist in early detection and cure, and thus contribute to reducing preventable morbidity. They would be trained to distinguish between what can be managed locally and what cannot, e.g., to distinguish between a common cold and pneumonia, and a mildly malnourished child from the need for referral for a severely low birth weight neonate or for neonatal sepsis.
- CHWs can best help individuals and communities integrate curative with preventative and promotional health care, as well as identifying and addressing the social determinants of

[2] By way of personal communication

health e.g. patriarchy, accountability of government systems, agricultural practices and vector control.

- CHWs can warn against irrational and harmful remedies, especially injections, drips and tonics, which have now reached serious proportions, and need public education to limit. We note that in many villages, the provision of some curative care is no longer the priority, since such a person has become available in the form of the almost ubiquitous RMP.

A third major critique is that the concept of a CHW implicitly assumes the existence of a relatively homogenous village community. In a study of the national CHW programme of 1978 in the tribal district of Shahdol in Madhya Pradesh, Imrana Quadeer (1985) concludes that the scheme treats the entire rural population 'as one homogenous mass without taking into account the reality of social classes and their dynamics' (ibid: 74). She finds that 'the exercise of giving *people's health in people's hands* through their *elected representative* may sound good on paper but is bound to get mutated by the social matrix within which it is placed' (ibid: 81, emphasis in original). Therefore, she finds that poor people, who needed the CHW most, were treated casually and without dignity, and were excluded from all significant decision-making about the scheme. Privileged social classes, who needed the CHW least, benefited the most from his attention and most influenced the running of the programme.

The same critique would apply to divisions of patriarchy, caste, religious groupings and disability, to all collective programmes for development and rights in unequal societies. Much would depend on the selection and training of CHWs and the degree of politicisation and organisation of the community. Women and persons from disadvantaged social backgrounds are more likely to reliably side with oppressed social groups, but even this cannot be generalised. Smaller units of coverage by each CHWs, such as hamlets or an even smaller clusters of neighbouring families, are likely to have more uniformly shared social, economic and political interests. However even here, fissures of gender, disability and age are likely to persist.

DEBATES AROUND DESIGN OF CHW PROGRAMME

Even within the advocates of the CHWs system, whether practitioners, academics or planners, there is very wide diversity in the design content of the principal elements of community based approaches. These include wide variation in terms of the scale of the work, qualifications, selection, training, remuneration and support to CHWs, their duties for preventive, promotional and curative health care and nutrition, and accountability and referral systems. There is similar variation in the design and practice of their links with

community institutions like PRIs and SHGs of women, on the one hand, and public health systems and programmes on the other. Finally there is large diversity of tools, instruments and community process that are deployed by the CHWs for epidemiological surveys, public health diagnosis and planning, implementation and monitoring.

In subsequent sections of this paper, I will attempt to capture both the major debates and some of the experiences around the wide diversity of practices in the design and implementation of CHW programmes, both in non-governmental micro-experiments, as well as larger state-led programmes. I will dwell on the responsibilities of CHWs, in particularly the balance between preventive, promotional and curative health care, and the degree of emphasis on various sectoral responsibilities for vertical health programmes such as RCH, TB, leprosy, malaria, HIV AIDS, nutrition and family planning. The paper will attempt also to study approaches to mobilisation, selection processes and responsibilities; the qualifications and social background of CHWs; unit of coverage and other motivational strategies; remuneration and other motivational strategies; training design, duration, agencies and strategies; referral systems, not just for curative care, but also for preventive and promotional functions (such as sanitation and nutrition counseling); community process that are deployed by CHWs, for epidemiological surveys, public health diagnosis and planning, implementation and monitoring; and links with community institutions, such as PRIs and SHGs of women on the one hand, and public health systems and programmes on the other.

The inputs are based on field visits to (i) Arogya Sathi Programme jointly implemented by CEHAT and Kashtkari Sangathan, in Dahanu, Thane, Maharashtra; (ii) The Arogya Iyakkam Programme in Vellore and Ramanthapuram districts of Tamil Nadu, implemented by Tamil Nadu Science Forum; and (iii) the Mitanin Programme of the government of Chattisgarh. I have relied further on secondary studies, reports and evaluations of other programmes.

I also held extensive discussions with Dr T. Sundararaman, SHRC, Raipur; Dr Ravi Narayanan, CHC, Bangalore; Dr Abhay Shukla, CEHAT, Pune; Dr Ritu Priya, Centre for Community Medicine, Jawaharlal Nehru University, Delhi; Dr Vandana Prasad, JSA, Delhi; Pradip Prabhu and Shiraz Balsara, Bhau and Prashant in Dahanu; Balaji Sampath of TNSF, Chennai; and innumerable CHWs, their organisers, health professionals and community members in several states. I have also been given access and permitted to use the insights from the vigorous and friendly debates that took place amongst the Jan Swasthya Abhiyan's leading activists with reference to the design of the ASHA programme, which is still on the anvil at the time of writing this paper.

FUNCTIONS OF CHWS

The first variations in the wide spectrum of the design of CHW programmes, is in the functions of CHWs**.** One issue is of the relative importance that is accorded within the CHW programme to curative care activities in relation to preventive and promotional aspects, as well as their sequencing. There is relatively less diversity in principle, but wide variation in practice. In theory, almost all CHW approaches include an element of curative care, in terms of first contact care, for which the rationale has already been elaborated.

However, most approaches in theory agree that the CHW must primarily be entrusted with those health duties that can neither be accomplished by the health bureaucracy alone, nor by the people alone. The CHW can best act as a vital link to bring them together, for preventive and promotional health, including a wide range of activities - such as health and nutrition, education and family counseling, water purification and maintenance of hand-pumps, sanitation, early detection and referral, pre and ante- natal care, safe deliveries and epidemic surveillance.

Some programmes acknowledge even more explicitly the inter-sectoral linkages between people's health and other sectors such as tribal and dalit rights, women's equality and livelihoods development, and place major responsibilities for health workers to catalyse community action in several aspects of development and human rights that are often not included within the boundaries of civil action for public health. In RUHSA, the Rural Unit for Health and Social Affairs of CMC Vellore, CHWs were involved also in grassroots work or agricultural improvements, water conversation, sheep-breeding and dairy co-operation.

Sectorally, most CHW programmes lay major emphasis on women and children's health and many include family planning and reproductive health. Health problems that disproportionately burden poor people are often included, such as leprosy, TB and scabies. Much rarer is the inclusion of mental illness and disability in CHW programmes; innovations in community based approaches in these two sectors typically are not integrated with other community health efforts, which remains a major flaw of community approaches to all three: public health, disability and mental health.

The careful balance between preventive, promotional and curative care, however tends to crumble in the implementation of most programmes, in which curative care frequently dominates and edges out most other vital CHW functions. I will illustrate this with a few examples.

The CHW scheme of the Government of India launched in 1978, included, impeccably, a number of duties of the CHW apart from the "treatment of minor ailments", such as health education, sanitations, nutrition, maternal and child care, malaria fever and communicable diseases control. However, various evaluations (see, for example, Kumar et al 1983) indicate that in the few places where the programme took off, mainly irrational curative care tended to dominate the activities of the CHW. Even for this limited role, evaluations found them woefully ill equipped. As Ashish Bose chronicles, "their own training emphasized curative care but gave them only the skills needed to treat the simplest of ailments. Though many tried to project themselves as the 'village doctor', their training in no way fitted them for this self-appointed role. As for disease-preventive and health-promotive work such as immunization, waste disposal, nutrition surveillance and education they were not trained (or expected) to handle any of these activities without strong leadership from the health Centre – that was usually lacking… Even in cases where the CHW and the community were aware of a serious environmental health problem – such as lack of safe drinking water – there was often little they could do about it without the backing of additional funds. A feeling of helplessness and frustration was the result." (Bose, 1983: 44)

The same was found to be the experience of the Jan Swasthya Raksha (JSR) Scheme, introduced state-wide by the Government of Madhya Pradesh in 1995. In this instance, curative care tended to dominate even the conceptualization of the role of the CHW in the programme. A major programme objective itself was stated in official documents to be to "improve the health in rural areas by providing a trained worker who can give first aid and treat small illnesses scientifically, in the village itself." (SOCHARA 1997: 8) Not surprisingly, an external review of the programme found that private practice, of mostly irrational curative care interventions like injections and saline drips, dominated perceptions of the programme - both from the CHW and the community.

Many NGO experiments with CHWs also are disproportionately overloaded in practice by curative care. It is often argued in defense of this that curative services must be front-ended in any CHW programme, because without these, a CHW will not be valued or respected by the community. It is argued that people will be more amenable to health and nutrition counseling, and other preventive and promotional health measures facilitated by the CHW, if the CHW extends services of a local doctor.

We have already agreed in the preceding section that there is no doubt that first contact curative care which is accessible, affordable, rational and appropriate is a frequently unmet health right of large populations, and therefore is a legitimate and necessary part of a CHW programme, especially in medically deprived regions and for socially disadvantaged groups. Studies have established that both in rural and urban areas, around 80 per cent of health care tends to be funded from the often highly strained resources of the patients

and their families. Around 80 to 85 per cent of doctors work in the private sector (Jesani, 1993), and drug suppliers abetted by the often untrained rural practitioners, promote irrational drug use. This is not just hazardous, but is a major source of rural indebtedness and immiseration. Therefore, if CHW can be trained, supervised and supported to extend rational low-cost first contact care, it must be welcomed.

The experience of CEHAT's Arogya Sathi in Dahanu is significant in this context. It was introduced in 1999 in the catchment of radical tribal movement for land and forest rights led by a powerful people's organization called Kashtkari Sangthan. One spur for a movement group to take on the agenda of public health (combining the principles of '*sangharsh*' with '*nirman*' or 'struggle' with 'contructive work') was evidence that illness is a major source of tribal indebtedness. Pradip Prabhu of Kashtkari Sangathan observes it was not uncommon for land and bullocks to be mortgaged for medical treatment, and recalls the case of a tribal family driven even to sell their son to cope with the expenses of ill-health.

They also saw this as a process of knowledge democratization and demystification. Many studies have established that the knowledge and skills of curative care are dominated by upper class and upper caste people (Sathyamala 1986 and Doyal & Pennell, 1981). The transfer of this knowledge to CHWs, and creating spaces for its appropriate and egalitarian convergences with traditional system of knowledge, are seen as ways of breaking this historical monopoly.

Therefore, in this experiment, curative services were introduced at the early stages of the CHW programme, along with the regular chlorination of wells and epidemic surveillance. CHWs were trained to fill a special deep pink surveillance card if more than 3 patients suffered from similar symptoms, and these have significantly controlled mortality in epidemics. However, the leaders of organization, such as Shiraz Balsara, said that they most valued among the outcomes of the programme, the struggles for people's health rights - such as agitations against shortage of drugs and staff in PHCs, in which they collected data on 139 mandatory drugs, of which only small supplies of 20 drugs were available at the PHCs. They held public hearings on neglect and denial of health care in government institutions, and demonstrations against quacks and unethical medical practices.

However, by contrast, it was remarkable that when I asked the CHWs themselves in Dahanu what they themselves valued most deeply about their work, they uniformly referred to the curative care services that they were able to extend to their neighbours. What they stressed was not their capacity to earn money, but their power to serve. "Our village is very remote, far from the nearest PHC or doctor. The nurse does not sleep in our village. After my training, if anyone falls sick in our village, it is our door that people knock on

at night." Another added, "I used to feel a lot of *daya* (compassion), for people who were sick and could not access medical care. Now I feel privileged that I can do s*eva* or selfless service"[3].

From the positive experience of CHW programmes that have delayed the introduction of curative care training and drug kits, I believe that the premium that CHWs and communities often give to curative over preventive and promotional health sometimes is the outcome of the sequencing of curative care in programme interventions. If it comes too early in the phasing of training and programme goals, even in the best and most progressive efforts, it may overshadow other aspects of the CHW's duties, including preventive health and health rights. In large government programmes, this preference frequently mirrors prejudices and perspectives of the medical personnel who run or supervise the programme, and their ignorance and devaluation of any health interventions that are not clinical (and that too based on allopathic medicine). It may be the outcome of lopsided priorities in training, or inappropriate selection of CHWs. Individual user-fee based programmes inevitably lead to neglect of preventive and promotional health care, as evidenced by the experience of the JSR in Madhya Pradesh.

Internationally, China's celebrated 'barefoot doctor' programme ultimately traveled this same path. As Kahssay argues, "China provides a special case of a CHW programme that formed the backbone of health service delivery to millions of people in the largest national health that had proven effect on mortality and morbidity. In the 1970s and 1980s, as a result of changes in economic policy and in the demand for medical care, barefoot doctors were offered the opportunity to become village doctors through training and qualifying exams. After training, these village doctors provided more sophisticated services, and in many provinces moved to a fee-for-service financing system. Thus a national CHW programme evolved to provide more highly trained personnel practicing privately rather than under the local government. The effects of this change on utilization of curative services have varied, but preventive and promotive services have declined" (Kahssay, 1998: 7).

However, all my field visits to Chatisgarh and Tamil Nadu have belied the assumption that communities do not value preventive or promotional services, or their providers - even when they do not 'front-end' curative services. In both programme, I encountered high levels of morale among the CHWs, and value for their work in preventive and promotional health by members of the communities, particularly women. During group and individual meetings with women in both states, I encountered high levels of value for and understanding of the contributions of the CHW, even though she was not dispensing any drugs. It is remarkable, for instance, that the Mitanin programme, which started work in May 2002 and is being extended to every hamlet of the state of Chattisgarh, did not even introduce the curative care elements until

[3] By way of personal communication.

at least two years of the programme had elapsed. Its focus remained during this entire period on health education, particularly on family level nutrition and health counseling, especially of women and children. A similar focus informed the non-governmental Arogya Ikkayam Programme implemented by the Tamil Nadu Science Forum since 1999.

Therefore, first contact curative care is no doubt an essential component of all CHW programmes, but care should be taken to ensure that it is not allowed to occupy central place in the programme, and to eclipse both the prevention of disease and the promotion of good health, on the one hand, and the struggles and demands for health rights from the larger system, on the other.

QUALIFICATION OF CHWS

Over the years, there has been varied opinion and more diverse practice around the issue of whether CHWs should be women and men, whether they should be literate and educated, and their social backgrounds.

The 1978 Govt. of India CHW programme, as also the MP JSR programme[4], did not prescribe any gender for CHWs. The outcome was that the overwhelming majority of CHWs selected were men. Ashish Bose in his review notes "the striking bias" in favour of selecting male CHWs: a mere 6.3 per cent were women. This seems curious, given that at least 70 percent of the users of the CHWs' services would have been women and children, who comprise the "most vulnerable section of the community." (1983: 45) Similarly, men predominated in the selection of JSRs, to the extent of 85 percent (Mohammad et. al, 2001).

Social and cultural barriers to women working are often cited as reasons for such a strikingly high male bias in official CHW programmes of the past. Mabelle Arole describes many of these barriers, which they had to overcome before they could operationalize a CHW programme exclusively of women. (Arole, 1994: 147) High educational qualifications may debar women in many regions from eligibility, and if the work is remunerated, then there is greater pressure from men who are socially more powerful. Men are also often reluctant to let women stay away form home for long periods. Gender relations play themselves out is other complex ways as well. A perceptive ANM told the JSR review team, "A family values a girl as a useful

[4] The state of Madhya Pradesh, responding to its own health situation and challenge, which includes a high unmet need of primary health care in the vast rural / adivasi areas of the state, launched the Jana Swasthya Rakshak Scheme in November 1995, under the Integrated Rural Development Programme for unemployed youth to provide round the clock curative and preventive and promotive health services in every village of Madhya Pradesh. In July 2001, the state Government launched the more ambitious Rajiv Gandhi Mission entitled Swasthya Jeevan Seva Guarantee Yojana (SJSGY) of which JSR scheme became an important component. In this report the old nomenclature JSR is retained for convenience.

person in several ways in the family chores, while an educated boy is often good for nothing. If not farming, nor doing any other work; they are loafing around, and parents therefore coax them take such a course rather than roam here or there" (Mohamman et al, 2001: 42).

However, numerous NGO experiments, and the more recent Chattisgarh state government Mitanin programme[5], have all demonstrated that if CHWs are exclusively women, they not only come forward to volunteer for this work, but have had significant impacts on health and nutrition behavior, practices and indices. (SHRC 2005B) Even internationally, women are preferred in national CHW programmes in most countries (Kahssay et al, 1998: 3)

There are many reasons why women generally make better CHWs than men. Firstly, women and children bear a greater burden of ill health. Secondly, improved health is impacted mostly by decisions taken within the household relating to nutrition, hygiene, child bearing, delivery and childrearing practices, and drinking water; and culturally, most of these decisions tend to be taken by women.

Further, "it is easier for women workers to reach the women and give them advice and teaching. They have access to the kitchen where the traditional policy of nutrition and child rearing of the family are determined by the dominating grandmother or mother-in-law. They are able to talk to women in their own terms" (Laugesen, 1976: 3-4).

Besides according to Antia, "biologically it is the women who have the caring and nurturing instincts, the key requirement for community health" (Antia, 2001: 48). Arole adds, that the "Village woman works on the farm and grows food or buys it from the market. She chooses the ingredients and cooks for the family. As the mother, she choose the family water supply, be it a river, a pond, open well, or tap, collecting and carrying it home and storing it. It is the woman who cleans her house and its surroundings. It is the woman who has to care for the sick in the family. In traditional societies around the world, only a woman can reach pregnant and lactating mothers and teach them about their own health and that of their infants". (Arole and Arole, 1994: 147)

The issue of the most appropriate caste and community of CHWs, and whether there should be affirmative action in selecting low caste CHWs, and those from minority communities, are equally complex. In initial

[5] The Mitanin programme was announced as far back as November 2001 by the newly formed Chhattisgarh State Government as an improvement on the JSR programme of the State of Madhya Pradesh of which Chhattisgarh was a part before becoming a separate state. The choice for the word 'Mitanin', meaning 'Dearest Friend' is inspired by a culturally hallowed and ritualized relationship that exist between any two women in Chhattisgarh who take vow to remain friends till death.

NGO experiments, low caste women were preferred by local communities not for reasons of equity but because "the tasks a VHW was expected to perform i.e take care of the sick, clean wounds and conduct deliveries, were thought to be 'dirty'. Further going from 'house to house' was considered 'immoral' for a woman to do. The high caste men who were often the powerful group in the village were therefore unwilling to allow the women from their own homes to work as VHW's." (Sathyamala et al, 1986: 211)

Over time, as CHWs gained in status and remuneration, more high caste CHWs, often from privileged land-owning and upper-caste families, were selected. The dilemma is that exclusive selection of CHWs from dalit groups may further reinforce caste prejudices. Even in the very progressive TNSF Arogya Iyakkam Programme of Tamil Nadu[6], I found that low caste CHWs would not counsel high-caste women in their homes. Instead, they took the opportunity to speak to them on the streets or at marketplaces. On the other hand, CHWs from disadvantaged social groups are likely to be more sensitive to the health needs and deprivations of oppressed groups and would accord them social status.

Ashagram, or a village of hope, was built in Barwani in Madhya Pradesh, for the rehabilitation of savagely excluded and stigmatised people living with leprosy. An unexpected problem arose within the new community when a dalit woman patient, Dhanno, went to fill water from the only handpump at Ashagram. The other leprosy patients, mostly tribal and some caste Hindus, angrily blocked her access to the water source. In the end, the young local administrator intervened, with a decree that the dalit woman leprosy patient had first right to the use of the handpump. If others had a problem with this, they would have to find some other source. There was sullen acceptance. But in time, the dalit woman volunteered her services as a health worker for the leprosy patients, and was trained informally by the Catholic Sisters. She ensured that their infections were detected at the earliest, that no resident of Ashagram prematurely terminated their drug treatment, and nursed the sores on their feet and hands to prevent the loss of their limbs and the consequent terror and stigma of deformities. Today, Dhanno is revered by her community for her dedicated daily service to them, freed from the stigmas of low caste.

Government programmes, and some NGO efforts as well, frequently stipulate a minimum educational level for CHWs. The Govt. of India guidelines for the 1978 programme prescribed a minimum formal education up to the sixth standard. The Madhya Pradesh JSR programme revised this upwards, to Class 10. Even the

[6] The Arogya Iyakkam Programme was initiated in May 1999 and the data for this report was collected in Jan-Feb 2001. The programme is implemented by Tamil Nadu Science Forum under the guidance of the Directorate of Public Health and with financial support from UNICEF. The programme was implemented in about 400 villages in 7 blocks in Tamilnadu – Andipatti in Theni district, Karyapatti, Tiruchuli and Watrap in Virudunagar district, Bhuvanagiri in Cuddalore district, Anaicut in Vellore district and Sakkottai in Sivagangai district.

draft guidelines of the National Rural Health Mission (unpublished) are considering the minimum requirement of schooling up to class 8 for the ASHA CHWs. Among the programmes that I visited, Arogya Iyakkam of the Tamil Nadu Science Forum prescribed high school education as a preferable criterion for all its women CHWs. In the Mitanin programme of Chattisgarh, literacy was preferred but not mandatory, and the evaluation study found 89 per cent literacy levels among the CHWs. In the Arogya Sathi Programme at Dahanu, there were both men and women CHWs, but many of the CHWs were non-literate.

A number of pioneering NGO efforts have established that low levels or even the complete absence of literacy do not impede women from performing excellently as CHWs. Training instruments and registers may need to be modified to rely exclusively on pictorial representations rather than words, but non-literate women have shown a high aptitude and capacity to learn. As Mabelle Arole remarks, "Are not women learning all the time? They take care of the home, they cook, they care for the animals, and they raise vegetables. You think they do this without knowledge?" (Arole 1999: 147). M. Laugesen confirms, "In villages where often only 10% of the women have learnt to read there are many intelligent, hard-working women among the illiterates. Many of these women have good memory, are good at conversation and good listeners." (Laugesen 1972: 10)

The WHO study group which has examined that international experience of CHWs, also suggests that "if the CHW programme relies mainly on briefly trained, part time volunteers, selection might emphasize qualities such as acceptability to the community and motivation more than educational attainment." (Kahssay 1998: 15) "Key attributes might be social standing, a long term commitment to the community to be served, and an ability to influence by word and example key sections of the community, particularly mothers." (Antia, 2001: 49) "The most important qualification of a CHW must be her willingness, aptitude and acceptability in the community. She should be the sort of person whom the women like to talk to, and the person they would turn to for help in times of trouble. She is often illiterate, and though this is some handicap, literacy is not the most important quality needed. The most important thing is that she is well-trusted and respected person and one who will work intelligently and energetically." (Laugesen 1978: 3). It is suggested further that preference should be given to a woman who is married and permanent settled in the village, whose children are fairly independent of her and whose family is willing to support her in her new role.

UNITS OF OPERATION AND MODES OF SELECTION

The 1978 Govt. of India CHW programme provided for one CHW for every 1000 population. Many CHW programmes are also designed to cover one revenue village per CHW. However, the greater consensus now is for smaller units of coverage, such as the hamlet, or even a neighborhood of 20 to 50 households. It is only such an approach that will ensure the regular outreach of the CHW to disadvantaged sections of the village, including geographically segregated dalit ghettoes. In many parts of the country, particularly tribal areas, villages are typically spread over hamlets often separated by several kilometers. It would not be realistic to expect a part–time worker to reach each of these villages as a regular basis.

Further many of her duties require intensive individual and family counseling, and follow-up with each women and child individually. For this to be effective, the advice of the CHW needs to be very specific and individualized to suit the child's needs as well as the specific family situation, resource and time constraints. This in turn entails direct and regular particular knowledge of the family, and intensive and preferably intimate contact with them. This is possible only in smaller and contiguous geographical units.

As far as the selection of the CHW is concerned, the consensus today is that she should be directly chosen by the households that she will work with, and that this should be non-negotiable. Neither health or other officials, nor even Panchayat members should make this choice. She should be accountable to the local neighborhood community that she volunteers to serve, for which she will be trained and supported by the health bureaucracy and Panchayats. Some propose also a formal ratification by the village council (Panchayat) or the Gram Sabha, or assembly of all adults.

It is agreed that the process of selection by the residents of a neighborhood or hamlet would have to be actively and sensitively facilitated. The Voluntary Health Association of India prescribes the following procedure: "It is not enough to just ask the Sarpanch Pradhan or Headman. He usually represents the leading caste or community. Minority groups must be consulted, not forgetting the women. We then tell them what type of woman is needed for this work. All this is best done by house calls, on say every tenth house, not forgetting the minority groups living on the edge of the village. We ask them which woman they would consult if they felt ill or depressed. Usually the same names will be suggested by many people. This information is then given to the village council for decision. If the VHW chosen proves unsuitable, this can be discussed again, and another appointed by the village council." (Laugesen, 1972: 4)

Even a large-scale government programme like the Mitanin programme of Chhattisgarh, prescribes the some procedure. The facilitator ensures that after all the families of the habitation are adequately informed

and interested in the programme, they sit together and select the Mitanin. As part of this process, a team of carefully selected and trained facilitators with a known public service record visits the villages and interacts with local communities, to help the community identify a woman in each hamlet who is willing to be trained and function as the Mitanin on a voluntary basis, and has mustered the family support to do so. The accompanying media campaign and *kalajathas*[7] ensure that many women volunteer for becoming Mitanins. They also identify and build a group of active women who would support her work. Special emphasis is placed on involving the Panchayats and its health committee in this task, and the Panchayat official in writing endorses the Mitanin selection (SHRC, 2005B**:** 8).

Whatever the prescribed procedure, there are often serious distortions of nepotism and patronage in the recruitment process, in all but the most small-scale experiments. Patriarchy, class, caste, communal and political power typically tend to muddy the waters, more so if the position is remunerated, focused on curative skills, or seen to be part of the official health bureaucracy.

An evaluation of the Mitanin programme tried to assess whether the prescribed procedure described earlier for the selection of Mitanins was followed. The evaluation study data shows that in 61.27 per cent of cases of Mitanin selection, village-level meetings had taken place - the single most sensitive indicator of a correct selection process. In other words, in as many as 38.73 per cent cases, the process of Mitanin selection had been inadequate. In some of these villages, a women's committee meeting may have made the selection and this is an acceptable alternative. However only in 21.61 per cent of cases was this reported, and in most of them village committee meetings had also taken place. The most common error that could occur is that the facilitator decides on behalf of the village, usually in consultation with the Panchayats members or in consultation with the Government employees like the ANM/AWW. This tends to be higher in NGO programmes, where the facilitators are from the NGO and are familiar with and obliged to many village level functionaries, or are themselves bureaucratic with little understanding of empowerment and processes required (ibid: 17-18).

The relative success of genuinely democratic and transparent processes of selection of CHWs, even in a large government programme like the Mitanin programme, is encouraging. This was attributed by Mitanins themselves in my focus-group discussions, to effective training of the facilitators, but also to the fact that the position was unremunerated and had very little initial curative care content. Therefore it was a less socially valued position at the initial selection stages of the programme, and consequently there was less jostling by various segments of the local rural power elite.

[7] Adaptations of folk theatre, music and dance to communicate social messages

REMUNERATION AND MOTIVATION OF CHWs

Possibly the most contested design issue in the CHW programme, even among its experienced practitioners and sympathetic policy makers, is the issue of remuneration of CHWs. There are many who argue that the CHWs should be adequately remunerated. Their reasons are that (a) it is fair and just to remunerate people for the 'opportunity cost' of their time. They argue that all public servants are paid, and there is no reason why CHWs who are often themselves impoverished, should not also receive a stipend to compensate them for their loss of wages for the time that they devote to their duties; and (b) it would not be possible to sustain the motivation of the CHWs if their work is purely voluntary. They doubt if team of thousands of volunteers can be sustained to work for several years without compensating them financially. Abhay Shukla, one of the founders of Arogya Sathi, maintains that "even in the context of a movement like Kashtakri Sangatana, with reasonably strong community support, the Arogya Sathis who started work in a semi-voluntary way with considerable enthusiasm in the early years, found it difficult to continue without any public system support after a certain period. Hence the learning for broader programmes, if any, should not be that 'rural women can and should work as volunteers indefinitely' but rather that 'selection of health workers and their work should be initiated with a voluntary spirit, and this spirit should be encouraged, but public health functions being performed by such health workers must be properly supported and remunerated by the public health system.'"[8]

Even most of those who advocate payment to CHWs would not like the health department itself to disburse the stipend or wages to the CHWs, because this would reduce her in the eyes of the health department, the community, and indeed in her own estimates, from a representative leader and servant chosen by and accountable to her community, to a poorly paid functionary at lowest end of the public health bureaucracy. Therefore the consensus is that even if the funds are contributed from the state exchequer, payments should be made by Panchayats, or by village health committees.

Some go further to suggest that emoluments of the CHW should be decided and raised by each community (Antia, 2001)**.** However, there is virtual unanimity that the raising of resources for the remuneration of CHWs "should *not* be based on her charging fees for prescriptions and services as a private practitioner, prescribing drugs in the open market - similar to what was attempted under the Jan Swasthya Rakshak programme of Madhya Pradesh. Glorifying this as a social entrepreneur should not blind us to the evidence accumulating that in programmes like the earlier Jan Swasthya Rakshak Programme, the rise of such a

[8] Personal communication

cadre of ill qualified private practitioners encouraged by the state itself raises the cost of medical care to the poor without any corresponding increase in health benefits" (NRHM, 2004: 10)**.** Individual payment for curative health serves creates a bias first against preventive and promotional health services (because these would not be compensated) and against the poor (because they would not have the capacity to pay). This strikes at the heart of the very rationale of the CHW programme.

Therefore, even if funds to pay CHWs are to be raised by local communities, it has been suggested that "compensation for services also may come from a fee per family paid to a common health risk fund maintained in the village. Payment of this fee would make the families eligible for the CHWs services as well as all primary and secondary care without any additional user fee payment - with the government paying the fees of the poorest. Thus this fee is a sort of insurance premium payment and goes in parallel with payments into SHGs for the poorest for whom the premium is paid by the government. The government provides the drug kit and the training to CHW and the investments for the PHC and the CHC." (NRHM, 2004: 11). Alternatively, some funds could be raised by Panchayats, along with a matching grant made by the government to the Panchayats.

There are also suggestions that emoluments should be linked either to loss of wages, or annual incentives that may be paid per year per CHW per hamlet for the achievement of promotional and preventive public health care outcomes - such as where immunization is fully complete, and every pregnant woman has been visited by a trained nurse, and whose delivery has been attended by a skilled birth attend and where the four first day interventions (visiting a house on the day a child is born, or a child has diarrhea or a child has cough or fever) is largely carried out by her (NRHM 2004: 11). However, if remuneration is indeed to be paid, it appears unfair to link remuneration to performance only for this rung of the state health machinery, whereas the ANM right up to the Health Secretary of the government are assured of their monthly emoluments, independent of performance or outputs.

Further, there is a smaller group, to which I belong, who are convinced that the benefits of paying CHWs greatly outweigh the costs, firstly because as we have already observed, if the functionary is to be paid, it immediately raises the premium and profile of the position to one that attracts patronage, nepotism, corruption and local power brokering. Of the 3 programmes that I personally studied in depth, in two, the Mitanin and the Tamil Nadu Arogya Iyyakkam, the CHWs were unpaid community volunteers, except for compensating them in some cases for loss of wages during training. I believe that the quality of selection and services of the CHWs was high to a significant degree because their position was seen as voluntary.

The experience of the third organization that I visited, Arogya Sathi, is instructive. Bhau, one of their health activists, told me "As long the programme was voluntary, there were no pressures of local patronage on the selection of CHWs, but once our programme converged with the state government's Pada Swayam Sevak Scheme[9] and the government introduced a stipend of Rs. 300 per month for each volunteer, the sarpanch's wife or daughter-in-law or even elected sarpanches themselves are selected, despite being specifically barred under the rules of the scheme."[10]. Now, especially outside the village where the organization is active, gram sabhas are known to be convened only on paper.

It is sometimes suggested that since only a very modest government stipend is being proposed for the CHW, it would not compromise her image as a community worker. The experience of the Anganwadi worker should be recalled here. At the time when ICDS programme was originally designed, the expectation was similar to the one being voiced for the CHW today, that she would be essentially a community worker, who would be paid a small stipend. It is instructive to note that today this is forgotten and the AWW is almost universally regarded as nothing more than one of the lowest paid government functionaries.

I repeatedly encountered evidence that the respect and credibility of the CHW was strengthened in the Mitanin and Arogya Ikkayam programme of Tamil Nadu, because she was seen as contributing *voluntary* service to her community. As an ANM in Kanker district of Chattisgarh put it, "when the Mitanin gives the same advice to a mother as I do, people value what she says much more than my words. This is because I am viewed as a paid functionary of government and therefore an interested party. The Mitanin on the other hand is respected for her disinterested selfless service."

The mass literacy campaigns undertaken in many parts of the country during the early 1990s, demonstrated that there is a huge, mostly unacknowledged and untapped, reservoir of public service aspirations in most communities, especially among women and youth. As Collector of Raigarh district in Madhya Pradesh in 1990, I observed that we were able to recruit 30,000 volunteer teachers in two months, and I used to be mobbed by young people in every village that I visited, demanding to know why they were not also selected as volunteers. Even in the contemporary Chhattisgarh Mitanin programme, groups of women have petitioned authorities to introduce the programme in uncovered areas, largely urban slums of small towns, fully knowing that no payment was being given, and making no demand that they be remunerated.[11]

[9] A programme of the Maharashtra Government, undertaken on a pilot basis in a few tribal districts, that provide for community workers at the level of the hamlet, with diverse developmental responsibilities
[10] Personal communication
[11] Personal communication by Mitanin programme leaders

It may appear on the surface unjust to deny people payment for work done, especially since most of us are ourselves paid functionaries. However, this neglects the fact that money is not all that at motivates women and men. There is the self-esteem of demonstrably contributing usefully to society, of being respected as a selfless community leader. This is particularly valued by those segments of our society, like women and educated unemployed youth, whose potential for socially valued contributions are relatively barred is normal times by cultural and socio-economic factors. For many of them therefore, the opportunity to volunteer and serve is also one to realize their own potential, as well as to earn social recognition.

It was remarkable that in the many meetings that I had with Mitanins is Chattisgarh, as with CHWs in Tamil Nadu, when I asked them what changes they would like to see in the programme, not once was the demand for emoluments raised with me. “We would like the doctor in the PHC to respond when we refer a patient to him. Today he ignores our referrals, we lose face and feel frustrated and saddened because our patient does not improve,” said one Mitanin, whose observation was widely endorsed. Where drug kits had been distributed, they asked for timely and regular replenishment of drugs. Many also asked for more training, recognizing that the knowledge that they gained gave them dignity, value and strengthened their effectiveness. One Mitanin said, “In old times people used to assist people who served the community is various ways – a fistful of grain from each house, or assistance in times of need of labour such as house building or rice transplantation. Today, these traditions are lost. But if they are revived, it would be a good ways for the community to support our work.”

One should not underestimate the value to these women of the opportunity to emerge from the confines of the four walls of their homes, and to not only discover the world beyond it, but also to contribute to processes to change it. As Mabelle Arole notes, “the average woman is a complete slave in her family, at the beck and call of her elders. When she goes to her mother’s house even her mother does not listen to her problems. She is told that it is her fate that she must learn to accept her difficulties. “She is told not to complain” (Arole, 1999: 185). Through their work, they experience freedom, agency and self-worth. CHWs affirmed repeatedly to me that this is what they valued most about their work, along with the social respect that they had gained. In the recent Panchayat elections in Chattisgarh, many Mitanins fought the elections, which would have been inconceivable for most in the past unless they were born or married into families of upper caste land-holders who traditionally held a monopoly over political power. There is data available for 5 of the 16 districts of Chattisgarh, in which more that 1100 Mitanins have won the elections, often displacing the entrenched village elite. In comparison, there would be almost no case of an anganwadi worker or helper who was able to make a similar transition through the electoral process.

The knowledge they gathered helped them also gain control over the extremely difficult circumstances of their own lives. As one said, "Earlier when my child fell sick, I used to fall into a helpless panic. Today, I am calm, because I know better whether it is serious or not and what needs to be done. As a result, I can help not only myself but also my sisters to deal better with the daily calamities of their lives."

I believe that far more than denying them an admittedly paltry monthly stipend, it is unjust to deny women the opportunity to voluntarily opt for the dignity and social esteem of public service. Each of us is made up of many parts: one part aspires for material well-being, another for the care and welfare of our families. But there are other human aspirations as well, among women and men, among the rich and the poor alike, for professional satisfaction, for social recognition, and for an internal sense of meaning that derives from the knowledge that you have contributed in some way to reducing suffering and injustice. It would be a great disservice to them if we assume that CHWs only have material aspirations. To the extent they do, and feel they need to contribute to support their families, this should be respected and ways should be found, by the organizers of the programme, the state, NGOs and the local community, to support their livelihood aspirations, but without reducing them to the status of low-paid salaried functionaries.

The motivation of CHWs cannot be secured merely by paying them. Many remunerated programmes (like the 1978 Govt. of India CHW programme and the MP JSR programme) have floundered and fallen by the wayside, despite payments by the state and by private practice respectively. Let us listen instead to what the CHWs themselves seek as ways of sustaining their motivation and morale. Numerous meetings with CHWs in Chhattisgarh and Tamil Nadu confirmed to me that what they seek most is ways of enhancing firstly their knowledge thorough creative on-going training, and secondly the effectiveness of their work, including through reliable referrals and regular replenishment of drug kits. They also value social recognition - therefore each CHW programme should build in structured ways, using the local cultural idiom, to periodically formally acknowledge and accord socially approbation for the contributions of the CHWs.

There must also begin a recognition amongst CHW programme leaderships, that a consistent corollary of not remunerating the CHW is a much greater investment in time and effort and resources in constantly renewing community mobilization processes, and providing regular support to the CHWs - by sustaining training as a recurring continuous process, constantly renewing itself throughout the programme, and constantly responding to the problems and issues of the people, that she articulates and seeks solutions to. Very often, paying the CHW is the easier and far less demanding way out of such large commitments of resources and human energy.

I end this section with a luminous quote from 'Jamkhed'[12], (ibid: 1), which I regard to be one of the finest human records of the evolution of a CHW programme, written from the vantage point of its impact as the lives of CHWs themselves. It speaks of an address given by a CHW, Muktabai Pol, who shares her experiences of providing primary care in a remote Indian village in a meeting hall in Washington DC. The Aroles inimitably chronicle:

> She concludes her speech by pointing to the glittering lights in the hall. 'This is a beautiful hall and the shining chandeliers are a treat to watch', she says. 'One has to travel thousands miles to come and see their beauty. The doctors are like these chandeliers, beautiful and exquisite, but expensive and inaccessible'. She then pulls out two wick lamps from her purse. She lights one. 'This lamp in inexpensive and simple, but unlike the chandeliers it can transfer its light to another lamp.' She lights the other wick lamp with the first. Holding up both lamps in her outstretched hands she says 'I am like this lamp, lighting the lamp of better health. Workers like me can light another and another and thus encircle the whole earth. This is health for all.' (ibid: 1)

The eloquence of a non-literate village woman because of the treasures of knowledge and public service that she has acquitted through her work, tells its own story. These are her treasures that money can never buy.

COSTS, REFERRALS AND CONVERGENCE

Costs

It is true that CHW programmes have one of the most favorable cost-benefit ratios. But they are by no means low cost and certainly it is neither feasible nor desirable to attempt cost recovery in a programme so specifically addressed to the poorest. Currently even if we put training costs at a modest Rs 150 per day and plan for 20 days camp based training and 30 days field based training at Rs 50 per day, the costs would work out to Rs 4500 per CHW per year. In addition training material and village level communication aids (a weak aspect of most ongoing programmes) and some degree of social mobilization costs would work out to Rs 500 per year per CHW. Administration and support would be at 10 per cent, or approximately an

[12] The Comprehensive Rural Health Project (CRHP), Jamkhed, Maharashtra, India, was started by Drs. Raj and Mabelle Arole in 1970. The aim of the health and development work is to enable and empower people and communities to take health into their own hands. *Equity, Integration* and *Empowerment* of people have been the principles of this project to improve the status of women and weaker sections of society. This approach has brought about overall development of the people including holistic health. Since the beginning of the project, 500,000 persons in 400 villages in Ahmednagar, Beed and Osmanabad Districts have been involved in transforming their lives and communities through CRHP.

additional Rs 500. These administrative costs include training of resource persons and trainers, sensitization of local bodies, department staff, some degree of social mobilization and the costs of monitoring such a dispersed complex programme. The drug kit costs are estimated at about 2400 per year per CHW for a population of about 500.

In a district with a population of 10 lakh, with about 10 blocks of one lakh each, we would expect at least 2000 CHWs (1 per 500), and in remoter more dispersed areas like Chhattisgarh, about 4000 CHWs (1 per 250). The district level costs would thus be Rs.110 lakh for training and support per year, rising to 220 lakhs in more difficult and dispersed populations. In addition the drug kit costs would be another Rs 120 lakh per year. Thus the cost of a district programme for a district of 10 lakh (one million population) is approximately Rs 230 to 340 lakhs per year.

In addition, funds for promotional and health-related activities of the Panchayat may be considered at Rs 1000 per month or about Rs 12,000 per year. Thus a district of 10 lakhs may have about 200 Panchayats, and therefore the least they would need is about a further Rs 24 lakhs per year. If we plan for the same amount of funding at a per village of 1000 population, then the costs would go up to 120 lakhs per year.[13]

It is these large costs combined with poor political will that has been one of the biggest reasons why the CHW programmes have taken so long to reach the national agenda, and some sub-critical funding can cause them to fail again. There is no reason for the state to hesitate from incurring such expenditure, given the evidence that such a strategy has an immediate impact on the health and lives of the poor, and also contributes to reducing poverty. A household level payment to a common financial village level, if resorted to, should fund primarily a risk-pooling facility, that makes the family eligible for a social insurance package - which has the CHW as one element and quality secondary care as a second element. This payment would thus be in addition to the state's investment in the CHW programme - not a partial substitute for it.

I believe that the entire costs of a CHW programme, including training and consumables such as drug kits, should ideally be borne by the state. This is because ensuring basic health care of all citizens is a primary duty of the state, and a fundamental right of all citizens (derived from the right to life). Communities should be left to find ways to support the services of CHWs, if they so choose to, and this can be in the way of grain, or donations of labour in times of family need, allocation of Panchayat lands or resources like tanks for fisheries. However, user fees for curative care services should be firmly debarred, as this would

[13] I have been assisted in this 'back of the envelope' illustrative costing of the programme by Dr T. Sundararaman, based on the experience of implementing a state-level CHW programme.

inevitably distort and de-prioritise the preventive, promotional, health education and health rights aspects of their work, and also create a bias towards serving those with the capacity to pay.

Referrals

Referrals tend to remain the weakest links of most CHW programmes. Th**is** problem is far less **evident** in small NGO initiatives**,** in which the organization itself runs a community health referral centre. In these cases, CHWs are trained to distinguish between cases that they can appropriately treat themselves, and those that need to be referred to medical practitioners. Many of these organizations establish linkages with charities or government medical institutions for further secondary and tertiary referrals.

However this option obviously is not available to large governmental initiatives that have to depend mainly on the public health infrastructure. There are also non-governmental organizations like Arogya Sathi in Dahanu and Arogya Iyakkam in the districts of Tamil Nadu, that choose not to establish their own active CHCs, but to consciously depend on the State's primary and community health centers, however inadequate they may be in their resources and services[14]**.** This choice derives firstly from the resolute health rights perspectives of these organizations, according to which it is the State's duty to provide health care services to all its citizens**,** and that it must be made accountable for this. Secondly a well-run non-governmental first referral heath centre may serve well the health needs of the immediate local population, but this is not a replicable solution if the programme is to be expanded on scale.

All the three programmes that I visited have chosen to depend on the State health institutions for their referrals, but in practice referral services flounder badly because of the inadequacies of the staffing, infrastructure and consumables in these centres. Particularly in Dahanu, I found that these difficulties have themselves fueled people's agitations for improved services and availability of essential drugs as their inalienable health rights. Some doctors have also become allies of the programme and are responsive, as a matter of conscious policy, to referrals from the CHWs.

However, these are exceptions and the general rule remains of poor, sporadic, disrespectful, even corrupt services from the public health infrastructure. This only underlines the learning that no CHW programme can succeed in isolation from the challenge of strengthening of PHCs and CHCs and indeed district level health institutions as well. It is useful to also specifically retrain the health professional in public health and to encourage them to participate in the training of resource persons, master trainers and at least occasionally of CHWs themselves.

[14] See for instance ICMR Report on the Conference on Evaluation of primary health care programmes, 1980.

Excellent results in referrals have also been achieved by the colour-coding of health cards. Cards of a particular colour are exclusively those that are referred by CHWs and ANMs, and systems are set in place to ensure that these receive priority in PHCs and CHCs. Their referrals in turn should be prioritized by district hospitals, and district hospital referrals by the medical colleges. This would encourage people to seek care at the appropriate levels and would decongest secondary and tertiary institutions and free their time resources for difficult cases that genuinely require the attention that only they are trained and equipped to provide.

Convergence

Linked to the issue of referrals are those of convergence. The challenges of convergence arise in many ways in any CHW programme: of the CHW with public health and ICDS departments, of the CHW with other government departments and of the CHW with Panchayats.

For convergence of the CHW with the public health and ICDS departments, it is imperative also to achieve clarity between them regarding roles, hierarchies and accountability systems. In any government CHW programme, especially one with provisions for a paid functionary at the level of a village, hamlet or neighborhood, the great danger always exists of the CHW being perceived by the ANM (but even more debilitating for the success of the programme, by the CHW herself and by the community) as constituting the lowest rung of the public health bureaucracy. This means that she would be allocated duties and supervised by the ANM, to whom she would be accountable.

In case the health worker is mobilized by the ICDS department, there can be a similar misperception of her subordination and primary accountability to the ICDS village level worker or AWW. For an NGO-run programme, the perils of accountability aligning *de facto* to levels within the NGO hierarchy, also exist.

However, any of these outcomes would destroy the genuine community character of the programme. The CHW was not conceived simply so that many of the duties of the ANM or AWW are undertaken and accomplished more successfully at smaller units of the village, hamlet or neighborhood. Essentially, the CHW was to be a facilitator of people's health education, planning and implementation. She was also to be a vehicle to help people realize their health rights, partly through people's monitoring of the public health and supplementary nutrition departments and services of the government at the local level. In order to achieve any of these, her accountability must be clearly and exclusively to the community or neighborhoods that select her, and whom she represents, mobilizes and serves.

These may be some public health tasks such as (most typically) family visits and health and nutrition counseling for health behavior change, that all these functionaries may perform, whether the health and nutrition departments of government or the community worker. However the state officials must be allowed to hold only their own direct functionaries (like the ANM or AWW) accountable for health and nutrition outcomes, and not the CHW. The CHW must only strengthen the informed demands on, and accountability of, the public health and nutrition systems, and optionally bridge some legitimate gaps in supply, such as ORS in diarrhea, or local food models in ICDS, as of first contact curative care. She would inevitably work closely with the ANM or AWW. But they must win and mobilize her support, rather than ever view her as their subordinate, whose services they can demand and take for granted. There should never be any compromise on the principle that the exclusive accountability of the CHW must be to the community, not to either anyone within the state or to any NGO.

We have already observed that problems and their solutions would require interventions with many other government departments as well, such as those responsible for clean drinking water, sanitation, agricultural extension, food and social security, education and literacy, and rural development. Correspondingly, to be effective, a CHW would need to work closely with all these local departments of government, both for local level convergence and public health referrals. Her position and relation with each of these departments must be no different, as with the public health and nutrition departments outlined earlier.

The issues of convergence and accountability are more complex in relation to the Panchayat or elected village council. Since the Panchayat comprises of the democratically elected representatives of the community, it appears legitimate that any community worker must be directly accountable to the Panchayats. This is the model towards which, for instance, a state like West Bengal with a strong and vibrant Panchayat system appears to be moving.

Yet although both the Panchayats and the CHW represent the people at different levels and in different ways, their convergence and overlap is not by any means neat and automatic. Many CHWs would represent the interests and voices of socially disadvantaged groups, and all would be expected to have an affirmative perspective on gender justice. If they are directly subordinate to a Panchayat that happens to be patriarchal, or represents the interests of upper caste landowners, the assertion of voices of women, agricultural workers, adivasis and dalits may be muted. Therefore, even with the local levels of elected government, the CHW can promote health and nutrition equity best if she works closely with local government, but retains and defends her independence from them.

In a small set (about 100 villages) CHW programme, such an ideal relationship may be possible to achieve by supporting the CHW by linkages to an ongoing social movement or to a motivated NGO leadership. In these programmes, the relationship with the local government, the AWW and the ANM, can be negotiated at terms advantageous to the CHW and the disadvantaged sections that she represents. However, in a large state run programme like the Mitanin programme, to reach to every hamlet, one has necessarily to go through at least one of the structures - the ICDS functionaries, the health department functionaries, the local government functionaries or the available NGOs. Even NGOs, when selected by the state, would display many of the limitations from which that the state and its department functionaries suffer. The Mitanin programme has tried to address this by creating a state level leadership structure committed to shaping the programme as an empowering movement. This carefully constituted state team (the state health resource center) which is itself drawn from both NGOs and government, then guides the selection and training and support to the district and block and village level teams, by negotiating with decision makers from within these four structures at each level, to maximize the level of commitment in the selection process of the district and block level functionaries, and then by building up commitment of whoever is selected through the training and support process. According to Dr T. Sundararaman, "Since the final choice is the outcome of a negotiation between this state team and official authorities, there would be wide variety in the level of pro-poor commitment in the programme, even a very varying level of conviction in the need for such a programme, but it would still be better then merely passively handing it over to one or the other of these structures without being able to maintain a constant dialogue and support to them."[15]

TRAINING CONTENT, METHODOLOGIES AND PERSONNEL

Training is the crucial element of any CHW programme, it is a fulcrum on which the effectiveness of the entire programme critically hinges, because it is this input that equips motivated but untrained CHWs to not only shoulder their wide and complex responsibilities for preventive, promotional and curative health, but also to educate and plan *with* the community.

In the path-breaking community health initiatives by NGOs that have illuminated the paths for contemporary efforts, training was mostly conducted by the leaders of these NGOs who were highly charismatic and capable public health professionals. This is, however, clearly not feasible if the programmes are to be substantially up scaled and state-supported.

[15] Personal communication

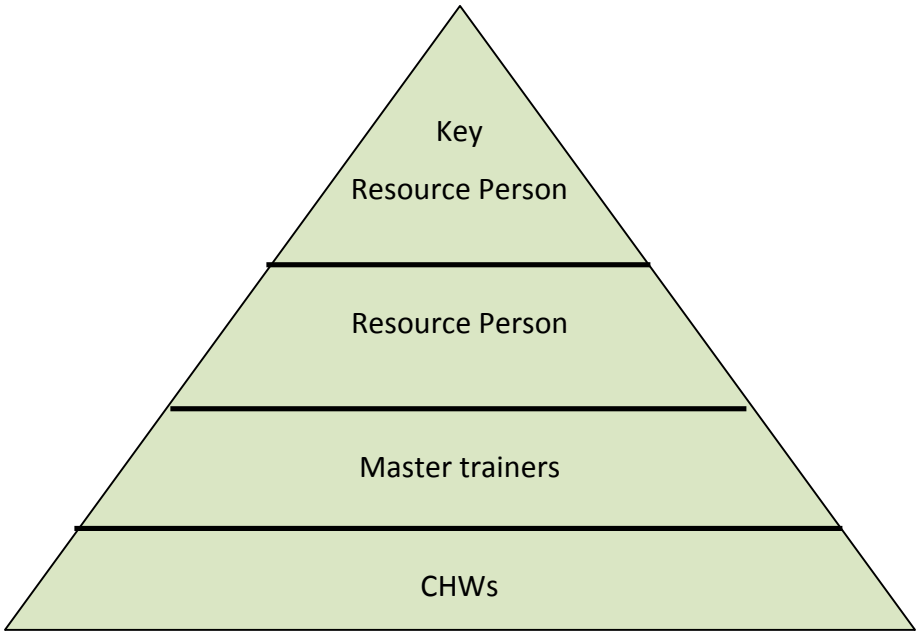
In earlier government programmes such as the Government of India CHW programme of 1978 and the MP JSR programme, the responsibility for training was entrusted almost exclusively to government health professionals, mainly doctors and sometimes ANMs. The large majority of them had an exclusively clinical orientation, and not only lacked any public health perspective; but were actually contemptuous of non-clinical health work. It is probably not fair to generalize, but they often have a problematic attitude to impoverished people and their health and coping behaviors. A VHAI study perceptively lists some of what it describes as the 'professional superiority complexes' of doctors and nurses, and the rare but vital skills needed from these trainers:

- Can the supervisor respectfully listen to and accept the felt health needs of the village as expressed by illiterate village leaders?
- Is the trainer committed to excellence in medical care at any price?
- Does the trainer have enough sympathy for village people or does he privately look down on them, for being tribals, low caste or not from his own state?
- Would he blame the patients for coming late in the illness, or blame himself for not having organized some health education earlier? (Laugesen 1972: 5).

In programmes like the JSR, CHWs were trained by Block Medical Officers, who were often poorly motivated and focused primarily on clinical skills. I have often observed JSRs aimlessly sitting in the corridors of the PHCs, during the training process. Not surprisingly, the evaluation found that the most valued and best-transferred skills of JSRs were of administering injection and syringes (Mohammad et al, 2001).

In Jamkhed, it was found that senior CHWs proved to be effective trainers, empathetic to the difficulties and cultural idiom of the trainees and excellent role models. However this too was a solution in an intensive micro-experiment with a record of excellence.

Programmes like Arogya Iyakkam in Tamil Nadu and Chattisgarh, have attempted to resolve this problem by drawing significantly from the experience of 'cascading training' deployed by the mass literacy campaigns of the early 1990s, represented in the diagram of the pyramid.



Cascading Training Pyramid

At the apex of this cascading training pyramid are key resource persons. For this, leaders of the programme and motivated public health professionals with an appreciation of working in the community and experienced social workers who have worked as trainers, including those available externally to the programme and the location, can be inducted. For all subsequent levels, it is not so much public health professionals but effective trainers who are deployed, as resource persons who in turn train master trainers. These master trainers are full-time workers; often experienced CHWs or literacy workers themselves, who not only train 15 or 20 CHWs each but also supervise and monitor their work on an ongoing basis.

This model has worked very well on scale, even accounting for the inevitable 'dilution' of knowledge and skills transfer that occurs at each level. A mid-term outcome evaluation of the Mitanin Programme found that out of more than 28000 Mitanins who were reported to have completed five rounds of training over 12 to 18 months, 72 to 80 per cent had actually undergone training. Despite the fact that no payment of compensation was made for livelihoods compensations to the Mitanin, the drop out rate after the first round was as low as 2 per cent. The same evaluation found high to moderate levels of knowledge and skills, which is especially impressive for a programme of this scale (Mitanin Evaluation Report, 2003). This establishes the feasibility of this model to train large numbers of CHWs, in short periods, mainly through skilled trainers who are mainly not medical personnel.

In order to introduce a balanced mix of training and public health skills, as well as to promote greater integration with the public health system, it may be useful to experiment with each master trainers being coupled for both training and support, with ANMs and Anganwadi (ICDS) supervisors ; and at the Resource Person level, with Block Medical Officers and block level ICDS Officers; and finally at the Key Resource Person level, with the Chief Medical Officer or a District Health Officer and the district head of the ICDS programme.

Most community health approaches agree that training must be on-going, with an initial extended induction phase followed by capsules at periodic intervals. The Mitanin programme, for instance, envisages 9 residential modules of training of 3 and a half days each, but their experience has shown that these modules should not be spaced too far apart, or earlier learning are sometimes not consolidated. They add that weekly or fortnightly review meetings are also an opportunity not just to review, but to learn from one another's experiences, the successes and mistakes of one's peers.

In the Indian rural cultural setting, it is a very major step for most women CHWs to be able to leave their homes and children for extended periods, both because the household is dependent on their multi-faceted labour, but also because of cultural barriers. It is an unfamiliar setting in which the women find themselves when they first assemble for residential and overnight training, living and working in close proximity with women of other castes, and trainers who may be men. Trainers must be sensitive to their fears and needs, including of toilets and child-rearing support for infants.

CHWs whom I spoke to everywhere recalled their first residential training experience as a watershed in their lives. Everything was unfamiliar. Their heads often hurt because they were unused to listening to lectures and handling books. They were shy about their articulation, and daunted by the need to cross the boundaries of caste and community. But they bravely persevered, because they deeply valued the knowledge that they hoped they would gain, that would enable them to control their own lives and serve others better, and for this they would mostly return.

Training programmes vary widely in content, and it is perilous to be prescriptive because the training design and methodologies have to be tailored locally to help meet the objectives of the overall programme, and the local situation, felt needs and challenges, yet here again, there are some major learnings. I have studied the JSR modules, and they are predominantly focused in curative clinical care, with condensed versions of anatomy, physiology and other key subjects of a medical doctor's undergraduate course. This does not orient and equip a CHW adequately for preventive and promotional health serves, nor for community epidemiology and health planning, and least of all for health rights.

The best training modules begin with a focus on understanding and interrogating society and the political economy, gender and perspectives on equity and health. There are then modules recommended on women's and children's health and nutrition, sanitation, hygiene, malaria, TB and leprosy. Fewer CHW programmes include also HIV AIDS, disability and mental health, but it is recommended that these too find place in the curriculum. Curative health components are best introduced later, with a focus on early detection and appropriate eclectic treatment, including what the CHW can herself treat, and what she should refer. Epidemic surveillance, early warning and initial interventions are also a vital component of any CHW programme. There should be a sensitive focus and social exclusion and how it can be addressed. Training should not delve only into the technical skills related to medical knowledge systems, but should also sufficiently prepare the CHWs to be well versed in community relationship-building skills as well.[16]

The epidemiological approach must be integrated into the training connected with all aspects of the community health workers' functions. The skills that need to be included are the ability

- To get to know the community by relating to people's every day life: the population, economy, social structure, environment and existing services
- To make systematic observations: recording, counting, classification and presentation of events
- To use the general epidemiological methods – namely, the identification of existing health and health care events or problems, the assessment of their magnitude, and their distribution in time and space and among type of persons; and the identification of the probable determinants of the problems and therefore of the relevant control measures within the health worker's reach. (WHO, 1982: 32)

Training manuals should rely extensively on pictures and culturally relevant case-studies. They should also be self–contained reference material, to which a non-literate CHW can return with the help of, say, a literate child in the family. In Jamkhed, CHWs contributed to developing their own materials, including adaptations from local stories. "A favourite one was based on a local aphorism that a child has to cross twelve rivers before reaching it their birth day. They identified the rivers as the common causes of death in childhood. Then, they asked why not build bridges across these rivers of death? These bridges were made up of breast milk, supplementary nutrition, immunization, early treatment of minor illness and home remedies with the mother of the family as the architect of the bridges". (Arole & Arole, 1999:173)

[16] In this respect I found a CHW training manual prepared by Canadian Department of health and welfare even in the 1970s (Department of National Health and Welfare, Canada 1970) a significant document that contain specific units such as, Communication, Interviewing, Working with groups, Leadership, Planning, working and counseling. These must however be imparted without being made overly technical; instead using games and local idioms and native modes of communicating and narration

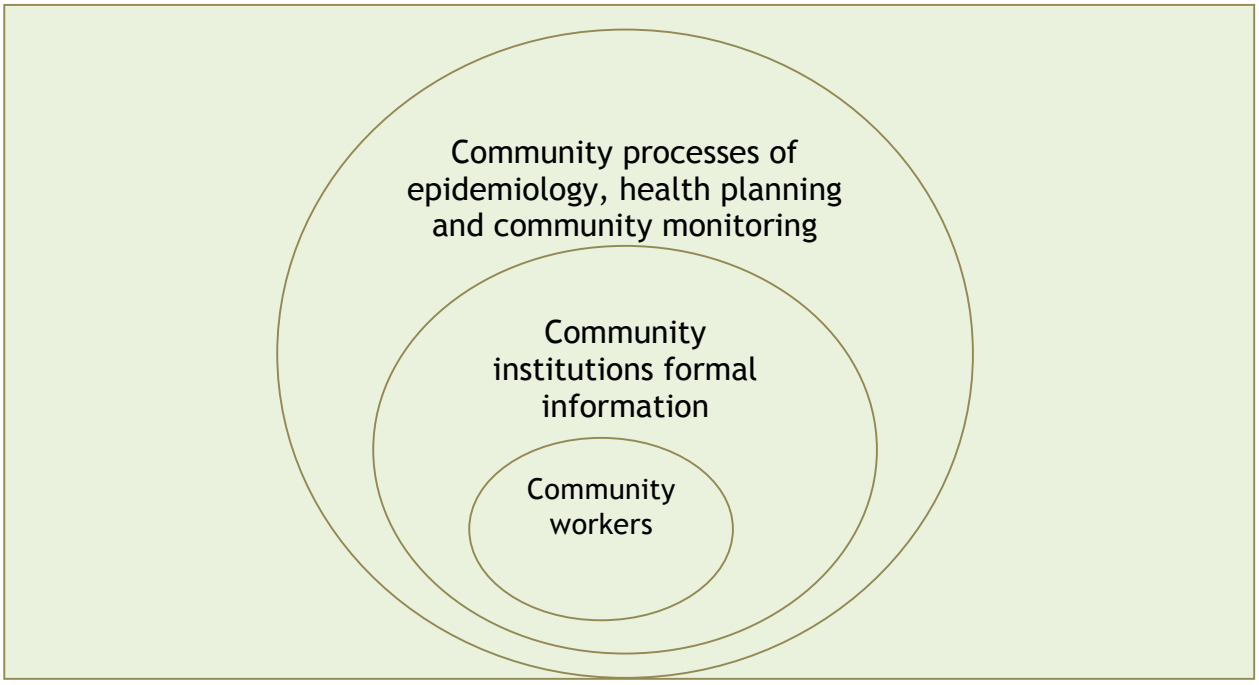
Even more important than manuals are the modes of transacting the training sessions. Mitanin training, for instance, relies a lot on role plays such as of family counseling of mothers. The Arogya Sathi programme uses games, such as listing symptoms and choosing whether to treat yourself or refer to a doctor. Initially, the bias of the trainees is for doctors, but then they analyse the costs and the capacities for CHWs and people themselves to handle the cases. They adopt popular games like Antakshari, and intersperse the training sessions with slide shows and films.

The most sensitive account in the literature of the training process is found in the writing of the Aroles (1999). Senior CHWs play the role of guides to the fresh trainees, and they begin by recounting their experiences. Trainees listen and learn respectfully from the women about how they survived in such an adverse socio-cultural environment, their perceptions of disease and poverty, and their coping methods. The training is flexible and incremental, a new topic added every week, following a critical discussion of the experiences of the previous week, derived from applying in their communities their newly acquired knowledge.

Lessons are drawn by CHWs themselves from their daily lives. “We feed the cow well in order to get plenty of good rich milk. Then why do we starve the breast feeding mother? We do not allow the baby to breast feed for the first three days of life, believing mother’s colostrums to be harmful, but babies drink the colostrums of the cows with relish. The goat’s kid is forced to suckle right after the birth and the kid immediately starts prancing around.” (Arole, 1999: 174)

COMMUNITY INSTITUTIONS AND PROCESSES

Most descriptions and discussions of community health interventions focus so much on the CHW, that it is often overlooked that the CHW is successful only if she is the facilitator of community institutions and processes. The CHW does not operate as atomized individual agent, responsible for bringing in mainly technical external inputs, into the community, but she is primarily a facilitator of community processes of health planning, implementation and monitoring, which she undertakes with the formal public health system, on the one hand, and formal and informal community institutions on the other. The diagram below tries to locate the CHW at the core of these community institutions and processes.



As Antia reminds us, "The chief asset of a CHW is her natural affinity and concern for her own community of which she is a member. It is this quality which differentiates her from all existing health functionaries. It permits her to achieve with relative ease not only the social functions of health but also many simple but nevertheless important technical and medial functions which more highly trained professionals are unable to deliver from a distance… Being a part of the community she is also aware of the local culture and practices as well as their 'little' traditions of health and medicine which would be difficult for any external professional to understand" (Antia 2001: 48).

The success of a CHW should not be assessed by her ability to deliver health services to the community she serves, as much as to organise the community to deal with the large majority of their health problems (estimated variously in the literature from 70 to 90 per cent) that do not require the intervention of health functionaries, and to make effective demands on the public health system.

The major objectives of community health processes and institutions would include:

(i) Health education and healthy changes in individual, family and community behaviour;

(ii) Health diagnosis and planning, at individual, family and local community levels;

(iii) Identifying and reaching out to geographically and socially underserved and excluded groups

(iv) Encouraging informed community participation in the preventions of morbidity and promotion of better health within the community;

(v) Promoting health rights and the accountability of the public health system.

(vi) Capability building, sensitising and bringing health as a priority onto the Panchayat's agenda. The Panchayat has always been discussed as the subject of CHW action – it is actually an important object of such action.

(vii) First contact curative care – the issue of providing some relief and a number of simple life saving measures

The actual experience of fostering community institutions for health has been uneven among various government and non-governmental institutions, and the systematic deployment of community processes shaky and scant. We shall examine each of these in more detail.

Community institutions can be both formal and informal. Among formal institutions are Panchayats, and their health sub-committees where constituted. In most parts of the country, engagement of Panchayats in community health and the degree of support and participation to the work of the CHWs has tended to be weak. This, for instance, was the findings of the evaluations, (JSR Evaluation, 2002; Mitanin Evaluation, 2003; CHW Evaluation NIFHW, 1983) confirmed by my personal observations of the Mitanin and the Arogya Ikkayam programmes). However, the neglect by Panchayats of health concerns is not intrinsic. The West Bengal experience has demonstrated that it is possible to mobilise Panchayats to both support the CHW, but also to plan health at the village level. The difference may lie in the vibrancy and the empowerment of weaker sections within Panchayati Raj Institutions as much as in the CHW programme design, for despite a very wide number of CHW experiments, few have been able to achieve the involvement of Panchayats in leadership roles. Nevertheless all programmes see it as an important way of engaging the Panchayats and prioritising health in their agenda and look forward over time to Panchayats rising, transforming to play their due role.

Most non-government initiatives, as well as the Mitanin Programme, lay high emphasis on mobilising women's group to support and participate in community health activities. These may exist even prior to the CHW programme, such as Mahila Mandals or women SHGs for thrift and credit, as be mobilised by CHWs themselves.

There are also practical imperatives for locating CHWs within vibrant and powerful local communities' institutions, particularly those of women. The experience of the Saathin programme in Rajasthan[17], demonstrated the grave perils both to the individual and to programme sustainability, of mobilising

[17] See for instance Harsh Mander's 'Unheard Voices' (Penguin India, 2001)

individual women, often low-caste and socially vulnerable, to intervene in socially sensitive practices like child marriage.

Besides, especially if the services of the CHW are unremunerated, there is no reason why over time she cannot mobilise several part-time volunteers to assist and share her work by undertaking specific agreed-on tasks - such as aspects of ante-natal and post-natal care, or ensuring that patients of TB and leprosy do not drop out of treatment.

Arole (Arole & Arole 1999) sensitively describes the initial difficulties involved in persuading women and their families to join these groups, and the barriers created by social hierarchies such as caste. CHWs are trained to facilitate discussions amongst women in these groups about their health and that of their children, and issues such as their unequal access to nutrition and health services, equality, discriminations, violence against women, early marriage, alcoholism and dowry. Many organisations believe that these groups will best sustain if economic concerns such as livelihoods and small savings are integrated into their activities.

Other initiatives have worked with agricultural workers' unions and forest protection groups. (Arogya Sathi, Dahanu), farmers groups (Jamkhed), and youth groups, especially to also engage young men in health and gender issues. CARE India in Chattisgarh has innovated with groups of mothers-in-law, to encourage them to be partners in the health, nutrition and intra-family equality of their daughters-in-law. They have also attempted to integrated modern health concerns with traditional institutions like the *ghotuls* of adolescent youth among the Mariya tribal communities of Bastar in Chatisgarh.

For *health education and behaviour change*, the most effective community processes, undertaken or facilitated by CHWs, have been found to be regular individual family visits by trained CHWs. These may relate to ante-natal, birth delivery and post-natal practices, child rearing and nutrition practices, sanitation and hygiene, support to disabled persons and their families, prevention and support to persons living with HIV AIDS, and early detection and sustained treatment of TB, and leprosy. Health education can be furthered also by group meetings, wall-writings, street theatre and *kala jathas*, literacy classes, and the transfer of health messages to the parents through the child in school.

For *health diagnosis and planning* at the individual and family levels, there is once again no better substitute to individual and family counseling. Of these family level interventions, four specific family level interventions which need to be done on the very first day and which are well within the CHWs capabilities, have been shown to bring around a steep decline in infant mortality. These would be an early

visit to the new born, for counseling the family inclusive of weighing the child to identify low birth weight babies who need referral; prompt home based management of diarrhea, early detection of pneumonia and its appropriate referral/care , and in high malaria areas the prompt treatment of fever. CARE India has adapted local cultural practices of women, such as the painting of auspicious patterns on the mud walls of her home, weaving of paddy hay, and embroidery, to assist pregnant women to themselves track various milestones such as regular and timely health check-ups and immunisation.

At the local community level, participatory techniques can be created or adapted for community epidemiology and people's health planning. Epidemiology, or the study of health events in a population, the frequency and distribution of illness and other conditions in the community, can help members of a community (often facilitated by a trained CHW) to identify the causes of health problems and indicate the ways so that they can be prevented and controlled (including curative care) **(**WHO, 1982**)**.

Ideally, community health involves a continuing (and supported) set of processes in the community, of collecting and analysing health data by the communities and identifying and addressing the causes of ill-health (See diagram). However, even in the outstanding experiments in community health that I visited I found these processes rarely applied in any sustained and systematic manner.

(i) Systematically collecting information about the population, its social economic cultural and political characteristics, endowments, deprivations and aspirations, and environmental features, and events. These would include "the numbers of residents, their distribution by sex, age, education, occupation and social groups and their way of life. The situation of the environment includes the local physical geography, the soil, crops and animals, water, housing, the disposal of excreta and refuse, and vectors and hosts of diseases. The events are what happen to the natural environment – seasonal changes and calamities; to the social environment – political – legal, economic and social changes; to families and individuals – births, deaths, conflicts, changes in social economic status. Events are also what people do: marriage, divorce, the services they provide to each other (including health care facilities), and the ways in which they hurt others, themselves and the environment." **(**WHO, 1982: 20-22)

(ii) The collection of data about the nature, magnitude frequency and distribution of particular health in the population, which sub-groups are most affected, where and when?

(iii) Scientific participatory analysis of the causes of health events, both the immediate medical causes and broader socio-economic and environmental causes. For instance, through clinical, laboratory research or field testing, it can be established that diarrhea events are caused by

enteric infection. These is turn are caused by infected drinking water or food. If there are repeated outbreaks in a family or community, these can be traced to say, a contaminated drinking water source like a well. Further social analysis may reveal that the community has no option to drinking this contaminated water, because of the practice of untouchability that may debar them from access to a clean source, or because of pollution by an upstream industry.

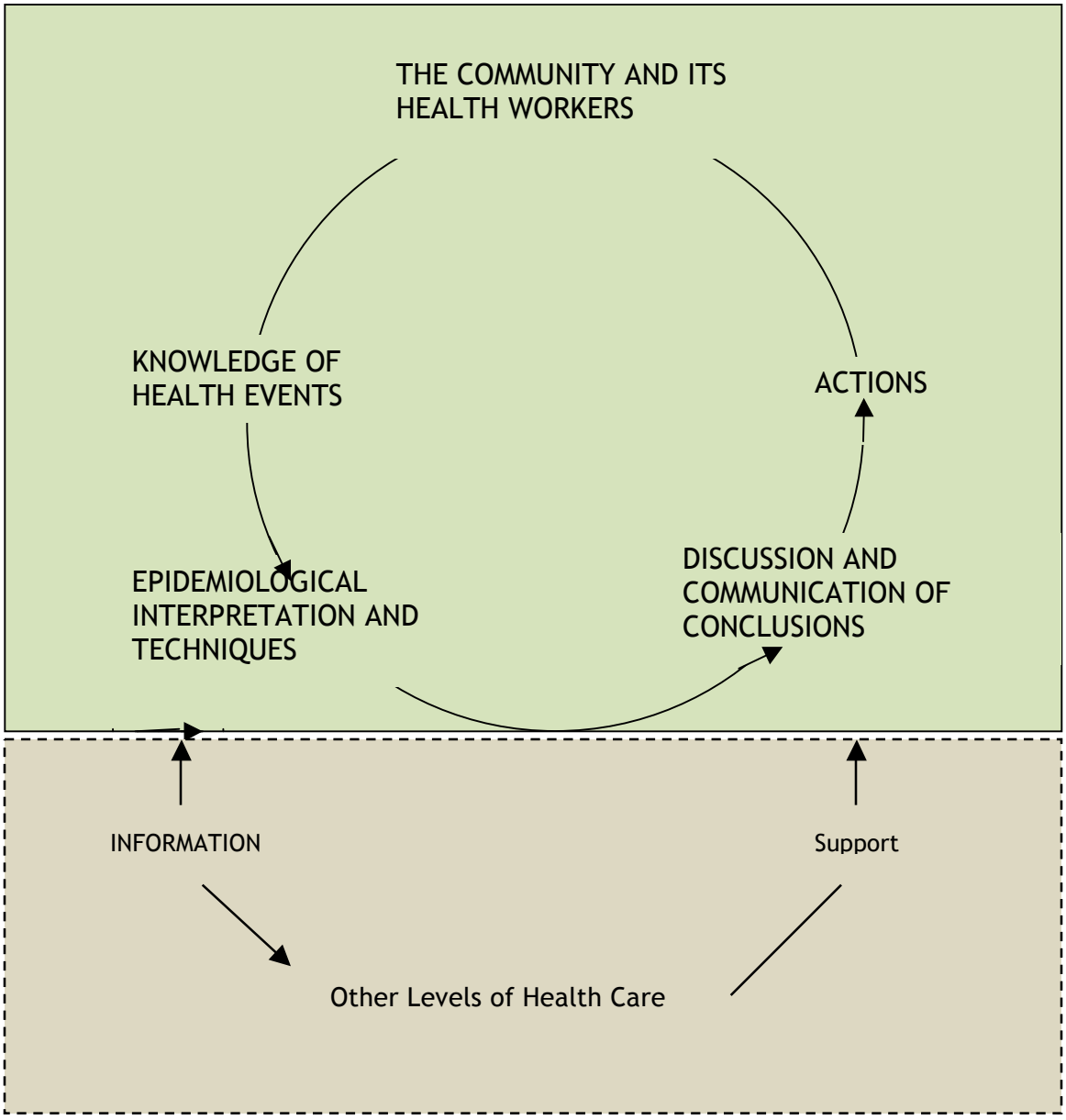


Figure source: WHO 1982.

[18] The contents of the segment on community epidemiology derives significantly from the WHO document (WHO, 1982)

(iv) Developing a programme of action to address the causes of these health events, so as to prevent further morbidity and morality. Using the metaphor derived from clinical terminology, once the community reaches a diagnosis, a community 'prescription' and treatment plan should follow. In the earlier example, the community may decide to purify through chlorination the existing drinking water source, it may choose to build a new, clean source, it may choose to petition government to take legal action against the law-breakers who practice untouchability or pollute public water sources, it may decide to take recourse to the courts or else it may decide to organise peaceful or violent direct civic resistance. The community members would weigh these various options to decide which of these alternative courses they regard as most feasible and appropriate in their view.

(v) Assessing the efficacy and impact of their health planning and implementation.

It is reiterated that whereas important components of each of these elements can be found in specific CHW initiatives, overall the strengthening of tools, instruments for each of the community processes listed above remain a major challenge in India, especially when the programme is poised to be upgraded to state and national levels.

These tools and instruments of appropriate epidemiology would equip CHWs and local communities to "attain a degree of self reliance in the guidance of their own work by their own scientific interpretation of local reality" (WHO, 1982: 5). The instruments need to apply participatory techniques and methodologies to standard epidemiological measurements like mapping, community surveys, analysis of birth and death registrations data (if reliable), and family cards and clinical records (where available). It would be important to demystify these instruments, make them culturally appropriate, and deploy pictorial symbols and focus groups discussions is order to make them genuinely accessible to people with alternate oral and graphic modes of communication, analysis and discourse.

Many of these instruments would also be relevant for the even more neglected tasks of identifying and addressing social and geographical exclusion. Social mapping can be affectively used to identify for instance, families with persons with disabilities, migrant workers, or working children or children from highly socially disadvantaged groups, who tend to be systematically, excluded from most government, and

even non-government community health and nutrition services. Likewise, it can identify the most food insecure families, like old people without care-givers and single women-headed households.

Reaching these groups requires special motivation and training, because many of them are socially invisibilised, in that most people even of the neighborhood do not acknowledge their existence. In my field visit to otherwise outstanding CHW programmes, CHWs consistently were not even aware of the existence of most of the disabled children even of their neighborhood, or of people most in danger of starvation. Therefore other techniques may also be deployed such as what is sometimes described as 'snowballing', where one disabled person helps find another, and she in turn finds yet another and the cycle is continued.

For promoting *health rights and accountability* of public health systems, some organisations have developed instruments for people's audits of public health functionaries and institutions (such as ANMs and PHC doctors, and sub-centers and PHCs respectively). This requires:

(i) A clear understanding of what are their specific duties, expected outcomes, resources allocations and regulations

(ii) Accessing, by applying the people's right to information, data about the actual performance of the public health institutions and functionaries, against information about their resources and allocations and the regulatory regime within which they are required to function.

(iii) Holding public hearings, in which the information and analysis of para (i) and (ii) above are carefully shared and explained to people who participate, in order to enable people to make informed assessment of the extent to which their rights have been realised, and of the performance of public health functionaries and institutions. Public officials would also be invited to these hearings, and accorded the opportunity to clarify and explain. In the end, the participants in the public hearings would try to fix the specific accountability for the identified failures or corrupt and illegal practices. A public hearing may establish, for instance, that a PHC is not stocked with adequate stocks of a majority of prescribed essential drugs. The public hearing would then have to identify as to which levels of the health bureaucracy are responsible is which ways for this situation (eg. adequate allocations not being made, allocations not being utilised, failures or corrupt practices in tender, PHC doctors not making requisitions or not prescribing drugs available with the PHC etc.)

(iv) In the final stages of the public hearing, decisions would be taken collectively about further remedial action, which may take several forms such as of departmental or police complaints, public agitations, or acceptance of regrets by public officials and their assurances for improvements in future.

In larger programmes managed by the government, there is a degree of contradiction between the role of ensuring accountability and the organisation of the programme through its field level functionaries. The experience indicates that if the selection process is adequately community based, and efforts are made to facilitate co-ordination, the CHW's role being expressed as facilitating the ANM and AWWs work rather than as holding her accountable – then in most of the villages a high degree of coordination occurs. The ANM is usually welcoming of such help. However there remains reluctance at the level of ownership of the programme, by not only the field level health functionary but by the system as a whole that only a determined administrative support at the top can counter. The more the need for accountability is to be enforced, the greater the reluctance in ownership and the greater the resistance. However, in areas where the selection and support is completely left to the AWW or ANM, the community ownership declines remarkably and that is the bigger problem. The nature and evolution of the supporting structure thus becomes critical and considerable efforts at building partnership between government and civil society and a wise, tactful leadership is needed to come up with a support structure that can address the complexities of this interaction, while retaining the space, the skills and the motivation to demand and enforce health rights and accountability from the official public health system.[19]

Since the Arogya Sathi Programme of CEHAT was undertaken in Dahanu by a radical mass-based organisation, the Kashtakri Sangathan, it has demonstrated notable successes in such civic actions for health rights. Among the issues that they have agitated for are unethical medical practices (such as unnecessary X-rays, surgeries and drugs) by both government and private functionaries; the availability of only 20 out of 139 drugs in the state list for PHCs; equipping and staffing a CHC for which the building was ready for years but had not commenced functioning; negligence or denial of curative services by government doctors; as well as right to food issues, domestic violence and alcoholism.

The successes have been mixed, but as Prashant, one of the health activist leaders of CEHAT put it, "It enables people to understand the politics of health rights and denials. It enables them to comprehend social-economic and political oppression from a different lens".[20]

[19] The perspectives in this paragraph were derived primarily from Dr T. Sundararaman, and his experience of leading the Mitanin programme with state support and the tight-rope that leaders of the programme always walked of upholding health rights but not terminally alienating the state government.
[20] Personal communication

SUMMARY AND RECOMMENDATIONS

For democratising public health, and enabling people to exercise greater control both over their own health and public health systems, the CHW is potentially an important and arguably even indispensable agency of the people. However, the deployment of CHWs never can, nor should, be allowed to substitute the public health systems of the state, and their preventive, promotional and curative care services - nor dilute in any way the principal challenge of strengthening primary and secondary public health institutions and services.

Role and Functions of CHWs: Instead of in any way substituting state responsibilities, investments and services in public health, the role of the CHW should primarily be of health education and mobilisation in the local communities that she serves, to assist people in understanding and preventing illness, and promoting better health for themselves, their families and neighborhoods through healthy practices relating to nutrition, sanitation, clean drinking water, rest and self-care. She should facilitate community epidemiology and health planning to assist local communities in understanding the medical, social and environmental nature, magnitude and causes of disease and death in their communities, and stemming from this undertake both 'community diagnoses' and 'community treatment plans', to reduce morbidity and mortality in neighborhoods.

The CHW would also provide residents of her neighborhood first contact curative care that is appropriate, accessible and affordable. Combining the best of both modern and traditional systems of medicine, she would also facilitate early detection and treatment of diseases through informed and timely referrals. Although the curative care component of a CHWs work is legitimate, cautions should be exercised to not let it overwhelm the less visible and immediate preventive and promotional health components.

The CHW should focus her services on the most medically underserved and nutritionally insecure segments of her neighborhood. These would include women and children in all communities. Women are especially at risk during childbirth; therefore maternal health should be a strong focus area of any CHW programme. However, women should be valued not just as mothers; and the structural denial of food, educations and health services and discrimination and violence, independent of their reproductive roles, should also be acknowledged and addressed. Among children, those who are malnourished, disabled and excluded from schooling because of work, migration or stigma, should especially be served by the CHW.

Along with woman and children, the special health problems of other socially and economically dispossessed and excluded groups require the attention of the CHW - such as migrant workers, agricultural

and other organised workers and small farmers, artisans forest dwellers and fisher folk, dalits and adivasis, people with disabilities, and people with stigmatised ailments like leprosy, mental illness and HIV-AIDS.

The surveillance, prevention and control of epidemics should also be among the major duties of any CHW. Since many epidemics in many parts of rural India are of gastrointestinal diseases or malaria, their duties would inevitably involve engagement with water borne ailments and vector control, along with an effective early warning system.

Finally, the CHW should assist communities to access services and demand accountability from public health institutions and functionaries, as their enforceable rights.

Qualifications and Selection of CHWs: The CHW must be a woman, who belongs to and is selected by the neighborhood in which she resides. There are many reasons why women are preferred. They bear a disproportionate burden of disease and malnutrition, and culturally they take most decisions that have the greatest impact on people's health - such as those related to nutrition, child bearing, child rearing and drinking water. They have been found to value the opportunity to both serve and lead their communities in health matters, with training and support, and to resist and struggle when health rights are denied.

Older women, married, widowed or separated, and experienced in child rearing, are usually preferred, because their advice is more acceptable to other women. They are also found to have more enduring commitment to their vocations. Since they are primarily to work with the most medically underserved segments of society, and these tend to be the most impoverished and socially excluded categories of people, affirmative action for selection of women CHWs from these categories is recommended.

Educational qualifications are optional, and it has been found entirely feasible to develop training materials and records using pictorial representation as a substitute for written texts for CHWs. Far more important are their acceptability and closeness to the community, and their level of motivation and aptitude.

The CHW must be selected by the local community within which she resides, and should be accountable exclusively to them. The unit that she serves should be compact and preferably homogenous in social composition, such as a hamlet or a neighborhood of 30 to 50 households. A trained facilitator may assist in the selection process, in order to inform the neighborhood about the role of the CHW, and ensure that the choices and aspirations of women and socially vulnerable segments are reflected.

Remuneration and Support: The opportunity cost of the time of a CHW when she participates in training or meetings should be adequately compensated. However, there are many reasons why her services to the community on a day-to-day basis should remain voluntary.

If a CHW works on a voluntary basis, her credibility and standing in her community are greatly enhanced. If paid, she is reduced to a humble and poorly paid functionary at the lowest rungs of the public health or nutrition bureaucracy, or the Panchayats - amenable to their control, instructions, and targets. In the eyes of the community, she would appear merely as a subordinate to the ANM and AWW, and her counsel would be devalued.

This changes significantly if both the community and state functionaries recognise that her services are voluntary. She is perceived with social dignity, and her advice is seen as disinterested and therefore is more respected and acted upon. The ANM and AWW have to seek and win her support; and the CHW has the freedom of space to assist the community to demand accountability from the public system, and even to take adversarial positions where necessary.

It is sometimes feared that it would be difficult to sustain the motivation of an unremunerated CHW. However, experience shows that much greater motivations for CHWs than petty stipends are derived from their opportunity to emerge from the confines of the four walls of their homes - to acquire, apply and share new knowledge, and to be socially esteemed as a leader.

The main support that they seek and need from the public health system is effective on-going training, regular and reliable replacements of consumables like drug kits, and responsive and effective referral and convergence systems.

Training must be ongoing, and must focus on the objectives of the programme outlined earlier - enabling the CHW, and through her the community, to undertake informed social analysis of public health and its determinants. Training materials should be creative and culturally appropriate, and methodologies innovative and interactive. These have all been elaborated earlier in this note.

I believe that the entire costs of a CHW programme, including of training and consumables such as drug kits, should ideally be borne by the state. This is because ensuring basic health care of all citizens is a primary duty of the state, and a fundamental right of all citizens (derived from the right to life). Communities should be left to find ways to support the services of CHWs, if they so choose - this can be in the way of grain, or donations of labour in times of family need, allocation of Panchayat lands or resources

like tanks for fisheries. However, user fees for curative care services should be firmly debarred, because this would inevitably distort and de-prioritise the preventive, promotional, health education and health rights aspects of their work, and create a bias towards serving those with the capacity to pay.

The weakest link in most CHW programmes, except those that are run on a small-scale basis by NGOs with their own captive community health centers, is of curative care referrals. Effective referrals require first the filling of the wide gaps that are rampant in most PHCs – those of trained personnel, equipment building and consumables. It requires further the genuine accountability of the PHC to Panchayats and local communities. In a CHW programme, systems for respecting and prioritising referrals made by CHW are crucial.

In this way, CHW programmes can never, and nor should they aspire to, substitute the public health system. However, they can act as a vital lifeline to assist medically and socially disadvantaged people to gain greater control over their own health, individually and collectively, and to secure more appropriate and accessible services when they need them from the public health system.

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