The safety of women health workers at the frontlines

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Abstract

This article, based on the report of the fact-finding team on the gang rape and death of an accredited social health activist (ASHA) in Muzaffarnagar in January 2016, attempts to analyse the issues of the safety and mobility of front-line women health workers. It argues that although the National Health Mission is often alluded to as a flagship programme of the government, it has failed in its basic responsibility as an ethical employer, since there is no support and back-up system that can be easily accessed by ASHAs in terms of dealing with the fallout of their social role as "change agents" in rural areas, and community reactions to their mobility and public exposure. The report stresses the need to consider the deeply patriarchal system within which ASHAs function in states such as Uttar Pradesh. It also discusses the fact that the workforce is increasingly shifting from the formal to the informal sector, which has given rise to an assumption that the employer is no longer accountable for women workers' safety at the workplace.

Introduction

Muzaffarnagar, in western Uttar Pradesh (UP), has often been in the news as a flashpoint for communal polarisation and caste violence, such as the riots of 2013. The local communities are extremely patriarchal in their attitudes towards girls and women, and gender-based violence, such as abduction and rape, followed by blackmail, is fairly common. The region is notorious for *khap panchayats* which mete out punishments to women and men who exercise their right to choose their own partner. In addition, the area is very strongly influenced by the Deoband *ulemas* who issue *fatwas* aimed at controlling the mobility and sexuality of Muslim women and girls to the greatest extent possible.

As in other districts of UP, the health department has deployed large numbers of community health workers, known as accredited social health activists (ASHAs), in Muzaffarnagar from the time of the National Rural Health Mission (NRHM; now National Health Mission or NHM). In January 2016, news reports were published about the gang rape and death of an ASHA worker in Muzaffarnagar.A small fact-finding team was constituted by women's health organisations, and health rights and human rights groups[1] to investigate the incident. The team interviewed the husband of the deceased, community leaders and women, including ASHAs in the district, as well as key police officials. This article is based on the report of the team, of which the authors were members (1). We begin with a description of the major events, as brought out by our brief investigation, and then provide our analysis of the ethical implications for the safety and mobility of front-line women health workers.

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To cite: Dasgupta J, Velankar J, Borah P, Hazarika Nath G. The safety of women health workers at the frontlines. *Indian J Med Ethics.* 2017 Jul-Sep;2(3) NS:209-13. DOI: 10.20529/IJME.2017.043

Published online on February 21, 2017.

Manuscript Editor: Sunita VS Bandewar

The incident and its immediate aftermath

The ASHA worker, S, had worked in her village, among a mixed neighbourhood of both Hindus and Muslims, for the last eight years. She also looked after three animals and had three children of the age of 16 to 8 years. Her husband is a heart patient and did not work; therefore, the entire economic burden of the family was on her shoulders. They were clearly from a lower-income group, and lived in a one-room brick house with unplastered walls and no toilet.

In the month of October 2015, S had gone for a postpartum home visit to a household of a different community. The woman concerned had returned after having her baby delivered in a hospital. Just as S was leaving, H, a young man who was the brother-in-law of the woman she had visited, accosted her and asked her to have a relationship with him. Although she refused, saying she had children almost his age, he persisted and began stalking her and calling her up on her mobile phone. This continued for almost three months. H asked her to marry him and then began issuing threats when she continued to refuse.

In early January 2016, a set of videos began circulating in the village on WhatsApp, showing H and a few other men pinning down and raping S. She was seen resisting and struggling with the men, with her clothes torn and her bag and slippers strewn around. Almost all the men in the village had seen the videos, and so had some women and even children; in all likelihood, her own children had seen them as well. Although the villagers acknowledged that they had seen the gang rape videos, it was not clear whether anyone had tried to help S or help the family to register a police complaint. The husband of S told the fact-finding team that on the night of January 11, 2016, she had discussed the videos with him. Although she was extremely distressed, he felt that she did not intend to take any extreme steps; in fact, she seemed determined to lodge a complaint about the rape with the police.

The next morning, January 12, 2016, S left the house to take her son to the doctor, but did not return with him. Later, her

husband got a call saying that she had been found lying dead by the road. They took her to a hospital, but she was declared brought dead and a post mortem was done. Her husband and a former village *pradhan* lodged an FIR that evening. The police recorded it under sections 376 and 306 of the Indian Penal Code, which deal with the punishment for rape and abetment of suicide, respectively, as well as 66A of the Information Technology Act, which deals with the punishment for sending offensive messages through communication services.

Later that evening, the police arrested H, the prime accused, and within a few days his two accomplices were arrested as well. The day after the death of S, a large number of ASHAs from the district and surrounding areas organised themselves and blocked the road, refusing to let the body be taken for cremation until the family received adequate compensation and justice. They called for a partial strike, threatening to boycott some national programmes until their demands were met. The family received Rs 5 lakh from the state government, although the Chief Medical Officer visited the family only after being summoned by the local MP.

The police found records of calls that indicated that H and S had had conversations over mobile phones for three months. They initially assumed that it was a consensual affair gone sour, and that she must have committed suicide. Although they were prompt in making arrests, they did not explore the "rape and blackmail" angle, although similar incidents have been taking place in the region. The ASHAs who have been agitating about this case are also feeling insecure. Some have been receiving lewd phone calls and some fear communal polarisation yet again, since the victim and the accused are from different communities. (1: p 8)

Discussion

Sexual harassment at the workplace

The Sexual Harassment of Women at the Workplace (Prevention, Prohibition and Redressal) Act, 2013, was the product of a very long struggle by women's movements against various forms of discrimination against and sexual assault on women at the workplace. A notable example was that of a rural woman activist called "*Sathin*", of the Women Development Programme (WDP), in Rajasthan. In the 1990s, she tried to prevent child marriage as a part of her duties, and as a punishment, was gang-raped by upper-caste men. Regrettably, the WDP practically washed its hands of the matter and she received no support from the government that had employed her. She received no justice by the legal route either, as the judge in the Rajasthan High Court ruled that "affluent upper-caste men would not (pollute themselves by having) intercourse with a lower caste woman". All the accused went scot-free.

Women's organisations such as Vishakha took up the battle through a public interest litigation in the Supreme Court of India (2), leading to a ruling in 1997, famously called the Vishakha Guidelines (3). These guidelines emphasised that sexual harassment at the workplace was a violation of the human rights of women, as accepted under the Convention for the Elimination of All Forms of Discrimination against Women (CEDAW),[2] and put the responsibility for the prevention of harassment and protection of women squarely on the employers, regardless of whether the woman in question was drawing a salary or an honorarium, or was a voluntary worker. These guidelines were used by the legislature to enact the 2013 Act (4). This statute superseded the Vishakha guidelines.

Implications for the safety and mobility of front-line women health workers

The case of the ASHA in Muzaffarnagar recalls that of the feisty *Sathin* of the WDP in Rajasthan. The latter was trying to bring about behavioural changes within her community. Today, the lakhs of village women who become ASHAs are meant to be "change agents" in the community, much like the WDP's women *Sathins*. ASHAs are seen as the backbone of the NHM intervention to save women's lives by changing reproductive health-seeking behaviour, and to improve public health in the villages.

While ASHAs are at the lowest rung of the hierarchy, with the fewest educational qualifications and often with severe disadvantages with respect to class, they are meant to deal with sensitive and difficult issues in the community. They have to get the community to accept and use contraceptives, bring pregnant women to hospital during labour, immunise children and pregnant women, and effect many other behavioural changes. Within the community, they are expected to counsel women, address their families and sometimes, address even the husband. In addition, their telephone number has to be known to the public. They are expected to arrive at any time of day or night to help a woman in labour get to hospital. They are expected to return from the health facility on their own at any hour of day or night once the delivery has taken place (since hospitals have no place designated for them to rest in). The health department in Uttar Pradesh has emphasised the fact that ASHAs are "*bahus*" (daughters-in-law) (5), meaning that they are grounded within their families and communities, yet working as "change agents" on behalf of the health department. Indeed, it is perhaps for the first time that many of these women workers at the frontline of community healthcare are stepping out of their traditional roles and the locally accepted boundaries for women. Many of them were earlier homemakers, home-based workers, or wage/farm workers.

In addition to ensuring fair working conditions and wages, we also need to consider the deeply patriarchal system within which ASHAs function in states such as UP. It needs considerable planning to put in place a support and back-up system that can be easily accessed by ASHAs. The support system would help them deal with the fallout of their changed social roles in rural areas, and the community's reactions to their mobility and public exposure. As far as their

unprecedented mobility and public exposure is concerned, careful preparation is required in terms of gender and empowerment interventions that prevent their exploitation, and protect them from unwanted attention or assault. It is also important to enlist the support of the community for the new roles of the ASHAs, even though these roles may differ from those of most women in the community. Further, one must see to it that the community takes its share of responsibility for ensuring the ASHAs' safety and protection.

In the case of S, she may have intended to seek help and report the rape, but her mysterious death took place before she could approach the police. Considering her death a case of suicide shifts the onus on her and diverts attention from the gaps in her support system. The men, women and youth in the village viewed the videos of her gang rape, yet none of them was prepared to stand up for her rights and help her to seek justice, even though she had served the community for eight years. It is possible that the video became a source of voyeuristic pleasure, rather than being a record of an action that should trigger shock. This lack of support from the community from which she was selected, and among the members of which she had been working for so long, points to a breach between the reality and the ideal envisaged role of ASHAs as "social activists", grounded within their neighbourhoods.

According to the ASHA Guidelines on the NRHM website, meetings of ASHAs are supposed to be held every month, and at these meetings, "they should be given (an) opportunity to share... their own experience, problems, etc" (6). Yet, in this case, for an entire three months the health department had no idea that S was facing sexual harassment and being stalked and threatened, including at work. Nor did she think of complaining to her employers or asking them for help, even though she was clearly in considerable distress. This indicates that ASHAs do not perceive that there is a support structure in their districts that they can access for help; nor are they equipped with the legal awareness to know that stalking itself can be reported to the police. In their review of the existing studies of ASHAs' working conditions around the country, Bajpai and Dholakia (2011) also find that "across studies, research emphasises the need for stronger ASHA supervision and support" (7).

Working conditions of ASHAs

Although the NHM is often alluded to as a flagship programme of the government, and the hundreds and thousands of women mobilised and trained as ASHAs are mentioned with a considerable sense of achievement, the government has failed in its basic responsibility as an ethical employer. The NHM has not guaranteed the ASHAs regular pay, proper working conditions, safety at the workplace or accessible forums to raise their concerns. Since ASHAs are at the bottom of the hierarchy of the health system in the country and, at the same time, have an extensive job description that is disproportionate to their remuneration, this is unethical on the part of their employer.

The job description of ASHAs demands that they should be able to deal with issues that are so sensitive that they might well jeopardise their own safety and well-being, or those of their families. They are supposed to provide counselling and support to women who are being abused, enable women to make choices regarding the use of contraceptives, and counsel women and girls on where they can access abortion services. As the "bridge" between the community and the public health system, they have to draw people into the health system, even if the system is failing to provide the required quality of health services, and they have to face the community's reaction when something adverse happens. They are paid a significant amount of Rs 1000 (8: p 36) if they can "persuade" a woman to adopt a terminal method of contraception after two children, but if any of the children does not survive, the ASHA will be the one to face the fallout of this in the community (8). Despite the sensitive nature of their tasks, ASHAs have not yet been provided with an institutional framework that addresses their safety and concerns. This reflects a lack of accountability and an unethical approach on the part of the employer, which is the government. This brings us to the question of whether the health department sees itself as accountable for ensuring the safety and mobility of ASHAs in the first place. There is a thin line between seeing them as workers and seeing them as volunteers or activists, who are primarily part of the community. As the 2010–11 NHSRC ASHA Evaluation says, while "we build in the concepts of voluntarism and activism", at the same time "we need to ensure that we do not become exploitative of her service, and that we ... compensate her adequately for her time" (9). In many states of India, there is no fixed honorarium/incentive/salary for ASHAs. Moreover, there are no fixed work timings and hence, they are required to work at odd hours, if necessary. Since they work out of home and their own neighbourhood is their primary workplace, it is questionable whether the "community" is even considered a "workplace" by the health department.

The fact that the workforce is increasingly shifting from the formal to the informal sector is giving rise to an assumption that the employer is no longer accountable for the safety of women workers in the workplace. The ASHA, who is seen as an "activist", is paid small amounts as occasional incentives for performing certain "voluntary" tasks. This represents a shift in tasks to the ASHA from the auxiliary nurse midwife (ANM), who was earlier the person employed by the health department to reach primary healthcare to pregnant women. Now it is the ASHA's task to identify pregnant women, mobilise them to avail themselves of services, and then bring them to health facilities during labour. Under the Revised Guidelines (8), they are paid Rs 300 to ensure that a pregnant woman gets herself registered for antenatal care, Rs 300 to bring pregnant women to hospitals for childbirth (in rural areas), Rs 150 for persuading women to accept sterilisation surgery, and Rs 100 for each child who has received complete immunisation (8: p 35).

However, the "piece-rate" nature of her work prevents the health department from formally recognising the ASHA as an "employee", towards whom it has certain responsibilities, including fair working conditions and wages. Even though they are "informal workers" of the health department, their needs have to be respected. However, so far, the trend has been to prevent them from asking for full labour rights, including formal employment, at all costs. The absence of social security extends to the lack of maternity leave, health coverage and life insurance, and they get no special benefits for being "volunteers". The NRHM Guidelines (2013) call the ASHA primarily an "honorary volunteer" and emphasise that the "voluntary nature of the ASHA programme needs to be preserved" (10).

As for fair wages, ASHA workers have been holding protests to have their compensation regularised, as it is different in various states. For example, West Bengal has a fixed honorarium of Rs 1500; Tripura pays Rs 3500, in addition to performance incentives; and Karnataka matches the Central Government's incentives. As for fair working conditions, health facilities do not offer the ASHA a room or a bed for the night, even if it is very late when she completes her work there. Nor do ASHAs get additional transport allowances for them to travel back safely from a hospital late at night when they are alone. Under the ASHA Guidelines of 2013, ASHA workers were supposed to be provided resting rooms in hospitals and an ASHA grievance redressal committee was supposed to be set up, but neither of these has been implemented (10: p 14).

Conclusion

Like many developing countries, India also adopted a programme involving the community to strengthen healthcare delivery services through front-line workers. ASHAs are similar to the Lady Health Workers in Pakistan, Community Health Workers in Bangladesh and barefoot doctors in China. A review of these examples and research suggest that thorough training, clear supervision structures and increased economic returns are required for optimal performance of community health workers (7).

Over 900,000 ASHAs and 180,000 ANMs work in rural areas to deliver healthcare (8).Yet, despite being the national flagship programme, the NHM does not adequately address aspects such as regular remuneration, social protection, fair working conditions or safety in the workplace. This reflects an unethical approach on the part of the institution itself. Further, the NHM has not yet ensured that forums are set up for ASHAs to voice their concerns or to provide them with an accessible mechanism for the redressal of grievances. It is potentially quite dangerous that ASHAs lack the knowledge required to perform their jobs, which could lead to serious consequences in the community (7, 8).The minimisation of risk is the ethical responsibility of the employer, and the state does not appear to have addressed this adequately. This tragic incident raises the question of whether the state has been able to provide a safe working environment for women workers at the frontlines of the health system, and raises ethical issues about the ASHA programme. On the one hand, calling them "activists" or volunteers gives their engagement a veneer of informality; on the other, the key outcomes of the health department are based on the local mobilisation achieved by these women. The informality permits the state to absolve itself of its responsibility for their safety, fair working conditions, and fair wages.

Taking serious note of the gang rape and suicide of an ASHA in Muzaffarnagar, the Ministry of Health and Family Welfare suggested in a letter to all states that they should set up complaints committees/cells headed by women according to the Vishakha guidelines, in every healthcare facility. It elaborated that these cells should promptly investigate cases of violence and discrimination in an appropriate manner. Besides, the states have also been asked to hold gender sensitisation programmes for healthcare workers (11). Some of this was supposed to have been done after the release of the ASHA Guidelines in 2013, but the lack of implementation has gone unnoticed till now (8: p 10).

The only ray of hope is that this tragic incident has helped to better mobilise the existing association of ASHAs in the area. The ASHAs of the district of Muzaffarnagar made a strong demand for justice in the case of the mysterious death of S. A positive response would make them feel more confident that such attacks on ASHAs will not be tolerated. They demanded that the compensation money be used to provide support to her young children. As for their own demands, they asked for life insurance, safe transportation back home or a bed to rest in at the hospital. In addition, they wanted to be trained to conduct safe deliveries in case there is no way to get the pregnant woman to hospital on time.

The most important demand of the ASHAs, however, was to be given the status of formal workers. They have served their communities and the country for almost a decade now, yet they remain informal workers paid by "piece-rate" for the tasks performed. It is called "performance-based compensation", but strangely, it is not applied to any others above the ASHA in the health system. The government must change its policy and adopt an "ethical employment" approach to ensure that the health system does not exploit rural female health workers. As the employer, the state must provide fair working conditions and fair wages to all women workers, even if they are viewed as "informal workers".

For ASHAs to function optimally, they must be assured of safety in the workplace; proper working conditions, such as a place to rest in hospitals or some support to travel back to their villages; and all forms of social protection, including maternity entitlements. The government must not short-change the community or the workers by failing to equip the latter adequately to perform their duties. It must accord priority to making greater investments in building their capacity and monitoring their quality. The career trajectory of ASHAs who show promise and potential over the years must be planned carefully, so that they have an opportunity

to access nursing or ANM training courses with state support (8).

In conclusion, it would be relevant to quote from the NHSRC Evaluation of the ASHA programme: "The challenge (is) to ensure that the ASHA's potential to facilitate change is not undermined by the quest for her rights and that her service towards saving lives and mobilising for change is not undermined by the denial of her rights."

Notes

[1] *Including Healthwatch Forum UP (HWF), ASTITVA Muzaffarnagar, National Alliance for Maternal Health and Human Rights (NAMHHR), Human Rights Law Network (HRLN) and SAMA Resource Group for Women and Health.*

[2] *Convention for the Elimination of all Forms of Discrimination against Women is an international treaty to uphold women's rights.*

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