THEME EDITORIAL

Exploring ethics in the implementation of the Community Health Worker programmes in India

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Introduction

The public health machinery in India is largely driven by the frontline community health workers (CHWs), namely the Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), Anganwadi Workers (AWWs) and other multipurpose health workers. They play a vital role as intermediaries between the community and the health system. The ANMs perform important tasks such as spreading health promotion messages, supporting behavioural change, surveillance of diseases, delivery of maternal and child health services at the doorsteps of beneficiaries, prevention of common minor ailments and other public health tasks, as and when the need arises [1]. The ASHAs are trained female health workers who mobilise people to utilise health services and also provide basic primary healthcare.

Effective implementation of Community Health Worker (CHW) programmes in India has helped in task shifting, where the responsibility for providing basic healthcare services has been shifted from doctors, nurses, and other professional healthcare providers to CHWs, who are able to perform these tasks effectively with appropriate training. Such task shifting frees up the skilled health professionals to deal with problems which only they are trained to handle [2]. It also helps cut the cost of delivery of public health services, as CHWs are paid less than trained healthcare professionals. However, deployment of the services of CHWs is associated with operational challenges and ethical concerns.

Ethical challenges of community health worker programmes in India

Several serious challenges arise while implementing the CHW programmes in India. The most fundamental ethical issue related to the CHW programme is the stark inequity in access to healthcare services between the rich and the poor. While there is unregulated proliferation of specialty and super-specialty hospitals and super-qualified doctors in urban settings, low-cost alternatives with much less training and limited skill-sets for CHWs are promoted for rural settings; and the urban poor areas are completely neglected, with no access to specialty hospitals due to the high cost, nor to CHW services. This widens the gap in access to healthcare between rich and poor. While the CHW programmes do take healthcare to many under-served areas, they fail to address the deep chasm between healthcare for the rich and for the poor.

Task shifting frequently becomes "task dumping". This overburdens the CHWs without any proportional increase in wages or reciprocal benefits to compensate for the risks they face. This was laid bare in the disregard for their welfare and safety that was seen during the Covid-19 pandemic. The National Health Mission originally envisioned the ASHAs as facilitators of public health services for childbirth, and childcare [3]. When the pandemic struck, in addition to their routine work, they were also tasked with case finding, contact tracing, testing, surveillance and reporting of Covid-19 patients [4]. They were both overworked and grossly underpaid in proportion to the enormous risk of infection to which they were subjected. Thus, task dumping is a major justice concern in the CHW programmes in India.

The ASHA programme — the largest such programme in India — is largely based on "volunteership". This implies that the ASHAs remain outside of the health system and are not integrated into it as formal employees, and are not paid a salary. Though they receive performance-based incentives, they do not get health insurance coverage, provident fund, and other benefits [5]. This unjust treatment of the ASHAs adds a further ethical burden to the programme. The CHWs are often used as a "cheap" means towards a larger end, namely providing primary healthcare to the community. There are reports of CHWs being raped and physically abused while performing their duties and even their lives are sometimes at risk [6]. Furthermore, the CHWs, being kept outside the health system as "volunteers", do not have any assurance of career progress. This lowers their sense of self-respect and

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their motivation to work and contributes to attrition. Given these inequities and poor working conditions, there is large scale unrest and attrition among CHWs, leading to lack of sustainability of the CHW programmes [7].

The World Health Organization released a guideline document in 2018 emphasising the health system policies and supports that are required to optimise the performance of community health workers. The document provides clear guidelines on the training and competencies that must be gained by CHWs prior to their deployment. The WHO guidelines make it clear that CHWs should receive appropriate supportive supervision; that they should not be paid exclusively through performance-based incentives; and that they should be provided a written signed contract of employment. The guidelines state that they should also be provided with a path to career progress, based on further education and experience. CHWs should be deployed only after adequate community engagement, and for their part, are to help in mobilising the community for public health interventions [8]. The ASHA programme in India does not follow many of these guidelines. Though there are several schemes on paper to motivate ASHAs with periodic revisions of their incentives, and a scope for career progress where some small portion of the NHM funds is channelised towards completion of schooling and ANM training of interested ASHAs — these are often not implemented, leaving the CHW programmes' ethical burdens unresolved.

The CHWs are that vital cadre which can access every nook and corner of the country and take primary healthcare to the most remote communities, which is acknowledged in the Astana Declaration [9]. In spite of all the above limitations, the effectiveness of the CHW programme in taking primary care to all is well known [10,11]. For instance, CHW-led maternal and child health programmes as well as HIV/AIDS control programmes have been demonstrated to be not only effective, but also extremely cost-effective [12,13]. Thus, optimal implementation of CHW programmes can create a substantial common good for the community. However, if CHWs are not adequately trained or are overburdened with work, it will inevitably affect the quality of their work leading to harm to the community. This was most evident during Covid-19, when the routine maternal and child health services and non-communicable disease services were disrupted due to overworked CHWs, who could not deliver them. There are also reports of irregular payment which demotivates the CHWs from performing their duties.

While the ASHAs receive only performance-based incentives, the ANMs and AWWs receive regular salaries with allowances. This discrimination between categories of health workers on the frontline creates unrest and frustration which compromises the quality of community health work [7].

The health system imposes targets on CHWs for specific tasks. The ANMs who are on regular salaries are also under pressure to achieve these targets. The incentives paid to ASHAs are directly linked to these targets, constituting an additional source of pressure. The CHWs face this conflicting accountability, on one hand to the health system and on the other to the community. There are stories of post-partum intrauterine contraceptive device insertion in young women who have delivered a baby, even without their consent, by CHWs to meet targets and earn incentives [14].

In a survey by Transparency International in 2020, it was found that 24% of the Indians surveyed admitted they had bribed health workers, clinic or hospital staff to receive medical care [15]. Cases have been reported of bribes, extortion, and exploitation of communities by CHWs. Good salaries, incentives and timely payments will help prevent CHWs from resorting to such corrupt practices.

Digital technologies are increasingly being incorporated into community health work. Some CHWs like ASHAs and AWWs, have poor digital literacy and find it difficult to adapt quickly to digital technology. The pace at which CHWs adapt to this technology does not match that of the digitalisation of community health work. This leaves community members vulnerable to data breaches and compromises the confidentiality of sensitive health information [16]. Digitisation of health at the community level involves costs for accessing a hand-held device, for its maintenance, and for purchasing mobile data. CHWs are frequently forced to bear these costs themselves, which deprives them of a substantial component of their meagre salaries and incentives. CHWs who do not have access to hand-held devices are often forced to depend on others who have them, and this weakens their sense of self-esteem.

Trust is an important value in the relationship between the CHW and her community. Often the CHW belongs to the same community in which she works, hence the community is familiar with her. This familiarity sometimes compromises trust, as the community members may fear breach of confidentiality and professionalism when dealing with her [17]. Thus, employing CHWs from the same community has both advantages and disadvantages. The compromise in trust may be a very important consideration in the effectiveness and ethics of community health worker programmes. Not only this, as described earlier, the CHW is herself confronted with a conflict of interest where she is accountable both to the community she represents and to the health system which employs her. This conflict becomes particularly problematic when the interests of the community and the health system do not align with each other. For example, during the Covid-19 vaccination drive, the health system insisted that the CHWs coerce all community members to take the vaccine, whereas the community members had their own apprehensions regarding the effectiveness and safety of the vaccines. Many CHWs were torn between meeting the timeline for vaccinating the maximum number of people and taking the time to explain and make people understand the need for vaccination. There is a

need to empirically explore the terrain of ethics of community health worker programmes and to understand these complex ethical issues. A sound understanding of the ethical issues will help design ethically robust community health worker interventions. Some of the ethical issues that need further exploration are – What level of tasks can be shifted to CHWs? How much training is required? How can the CHW's working conditions be optimised to make her functioning more effective and enhance the common good to the community? How can justice and fairness be ensured in CHW selection? How can the burdens and benefits to the communities as well as the CHWs be distributed fairly? How does one protect the privacy and confidentiality of community members in CHW programmes? How can professionalism and professional boundaries in a CHW programme be ensured where the CHW is part of the same community? Who is a trustworthy CHW? Detailed theoretical and empirical exploration of these issues is a pre-requisite for strengthening the CHW programmes in India.

In this theme issue

This theme issue on the ethics of community health worker programmes has emerged from a Public Health Ethics WriteShop organised by the Rural Women's Social Education Centre in Chennai from April 7-9, 2022, in which ten public health scholars from different parts of India came together to write articles reflecting on the ethics of community health work. These scholars were mentored by senior ethicists and academics in the field of public health ethics. Five of these papers have been included in this theme issue and are summarised below.

Ajith Kumar and Sudharshini Subramaniam describe the dimension of ethics of community health workers as gleaned from their interview of a senior village health nurse with 38 years' experience in Tamil Nadu [18]. They use a virtue ethics framework to describe "what kind of person a CHW should be", rather than "what a CHW should do". They argue that CHWs in India are an integral part of the community, so it is difficult for them to maintain professional boundaries. In this context, describing "what one should do" would be more challenging than describing "how one should be".

Anuj Ghanekar explores the ethics of training of ASHAs in Gujarat [19]. He presents the argument that ASHAs working in rural and urban areas work in completely different contexts and therefore their training needs are also different. He says adapting the training modules of ASHAs from the rural context to train ASHAs in the urban context would be unethical, as it would leave ASHAs in the urban context underprepared to perform their duties.

Sathish Rajaa and Balasubramaniam Palanisamy present a scoping review of factors influencing the sustainability of community health volunteers [20]. Providing incentives, security, adequate family support, appropriate transport facilities, identity and recognition as a good health worker were factors that motivated the CHWs and ensured sustainability.

Pavithra Arunachaleeswaran and Anant Bhan contribute an interesting paper on the dilemma faced by community mental health workers regarding the age of consent of young people for treatment for mental illnesses [21]. They argue that the chronological age of consent is not relevant to all youngsters who need mental healthcare.

Vijaya Raghavan and Sanjana G present the findings of their qualitative research with community mental health workers who delivered a school-based mental health intervention for youngsters [22]. They highlight the key ethical issues faced by these CHWs. These papers cover a wide range of ethical issues pertaining to community health workers. They include the ethical principles underpinning the work of CHWs, ethics of training of CHWs, sustainability of the CHW programmes, the handling by mental health workers of ethical conflicts in the field, and the issue of conflict between ethics and law when it comes to age of consent for mental health services. As stated earlier, the Covid-19 pandemic served to expose the several flaws in these programmes which need to be addressed urgently. This theme issue is intended to generate more scholarship in this area, advance the agenda of creating an ethical discourse related to community health work and workers in India, and lead to enrichment of these essential programmes for public health delivery.

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Statement of conflicts of interest

I would like to declare that I am the principal investigator of the project titled "Ethics and professionalism among community health workers in Tamil Nadu" and was one of the organisers of the public health ethics WriteShop. However, I did not involve myself in writing of the manuscripts either as a mentor or as a commentator during the WriteShop. Of the authors of the papers included in the theme issue, Ajith Kumar was a student in my department till 2018, and Sudharshini Subramaniam is one of the co-Investigators in the project

mentioned above. Sathish Rajaa is a colleague, both of us serving as Assistant Professors in the same institution. All editorial decisions were taken by me in consultation with the chief editor.

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