Community Health Worker Programmes

Essential Elements and Enabling Environments

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Preface

The National Rural Health Mission (NRHM), launched by the Government of India in April 2005, has laid out an important agenda to systematically invest and improve the quality of primary healthcare in rural India, especially across 18 states.[1] The cornerstone of this initiative is the introduction of community-based women health volunteers to be known as Accredited Social Health Activists (ASHAs). The ASHA has re-focused attention on a long history of community health worker initiative and challenged state governments and civil society innovators to facilitate and sustain community mobilisation for health on a large-scale across the poorest regions of the country.

Written in the context of national and state-level preparations for the implementation of the NRHM, this paper is an attempt to synthesise some of the critical conceptual and operational issues related to large-scale public programming in India involving community health workers. Drawing on both available literature on various Indian and international experiences, as well as intensive dialogues with programme implementers and field visits to some of the initiatives described, the paper presents a perspective on the approach, key elements, essential contextual factors and partnerships involved in putting such programmes into practice. Given the wide range of experience and innovation in this field, the review is by no means comprehensive and while select illustrative examples have been used in various sections, there are many more that have been tried out on the ground. It is hoped, however, that by presenting a concise analytical overview of experiences and programmatic options, this paper will contribute to the varied and unique discussions and decisions that will shape the ASHA programme in different states in their common goal of supporting and sustain community-based health action and change in rural India.

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[1] Uttar Pradesh, Uttaranchal, Madhya Pradesh, Chhattisgarh, Bihar, Jharkhand, Orissa, Rajasthan, Himachal Pradesh, Jammu and Kashmir, Assam, Arunachal Pradesh, Manipur, Meghalaya, Nagaland, Mizoram, Sikkim and Tripura. (http://mohfw.nic.in)

Conceptual Crosscurrents

Many of the debates around community health volunteers and workers in the context of public programmes arise from a central tension regarding their positioning at the interface of community processes and public health systems. It is this very tension that is embedded in the widely accepted definition of community health workers (CHWs), first presented by a World Health Organisation (WHO) Study Group (1989):

> Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily part of its organisation, and have shorter training than professional workers.[2]

While this definition outlines the crucial relationships informing a CHW's positioning, it is the *nature* of the support provided by the health system to both the community and CHW that is much harder to negotiate and is crucially dependent on the way in which a programme is conceptualised and implemented. This is especially complicated when, as is the case in almost all large-scale public initiatives, the state itself invests in initiating community participation rather than responding to an already active expression of community demand. As a result, Community Health Workers (CHWs), like many of their counterparts across the development landscape, have tended to fall between two perspectives: one that sees them as agents of empowerment, activism and social change, while the other, views their role as extending access to services, linking communities and formal systems, and playing a predominantly "community management function".[3] In her most recent Indian *avatar*, the ASHA, which stands for Accredited Social Health Activist, continues to embody this dualism, reprising the role of activist, but at the same time one accredited and sanctioned by the formal system.

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[2] WHO, *Strengthening the performance of community health workers in primary healthcare. Report of a WHO Study Group.* WHO Technical Report Series 780. Geneva: 1989.
[3] Lehmann, Uta et al, "Review of the Utilisation and Effectiveness of Community Health Workers in Africa" Joint Learning Initiative (2004)

These different conceptual paradigms are not merely ideological debates between government officials, policy makers, and civil society activists, however, but translate into the actual roles, training and support provided to the CHW. Should she be positioned as an agent of broad-based empowerment and social development with health as an entry point or is she seen as a local carrier of certain kinds of technical knowledge and services prioritised by national and state health departments? Should her capacity building emphasise political and social systems and methods of mobilisation or concentrate on the retention and communication of specific and narrow health education messages? Most importantly, how does this determine the ways in which community members and health system functionaries interact with her, a contested relationship once famously described as "lackey or liberator?"[4]

Situated within the lived realities of poor communities and the contexts of resource-constrained public health systems, however, it is possible and indeed vital for these seemingly opposing rationales to be successfully integrated. In the sections that follow, this paper will continuously seek to emphasise the need to conceptualise community-based health worker programmes at the heart of two interrelated processes:

- Sustainable community-owned and driven health empowerment and change, and
- Strengthening of primary healthcare systems and services

From the outset, this requires planners and programme managers to acknowledge that while community health worker experiences across the world have demonstrated their potential as cost-effective strategies to improve a range of health and nutrition outcomes,[5] they are also essentially complex social and political interventions requiring multi-leveled resources and commitment. Creating a unique space for the CHW – within her community, within the programme and within – or in relation to – the public health system can enable the positive dimensions of these systems and structures to facilitate rather than impede her work. Indeed it is the interplay of both programme inputs and

[4] Werner, David. "The Village Health Worker: Lackey or Liberator" First published in 1977. http://www.healthwrights.org/articles/lackey_or_liberator.htm

[5] For a review of the effectiveness of different CHW programmes in Africa, see Lehmann, Uta et al, "Review of the Utilisation and Effectiveness of Community Health Workers in Africa" Joint Learning Initiative (2004). In the context of Asia, especially Thailand's experience in improving maternal and child nutrition, see Tontisirin, Kraisid and Gillespie, Stuart, "Linking Community Based Programmes and Service Delivery for Improving Maternal and Child Nutrition" in *Asian Development Review*, vol. 17, nos. 1,2, pp 33-65 (1999).

community resources that enables the CHW to be most effective. For instance, while it is her position as a member of her neighbourhood and community that allows her to access and negotiate behavioural change within families often with greater success than an external functionary, it is from her constant interaction with the programme that she can source relevant knowledge and technical explanation, for which in turn she is valued by her community. On the one hand, careful facilitation and support from the programme and health system can reduce the risk of her becoming too entrenched within village dynamics, politics and discrimination, while on the other, it is the strong backing of her community that can ensure that she does not end up as the lowest rung of the health delivery system. In addition to financial and technical resources, therefore, large-scale community health worker programmes of the kind proposed under the NRHM require innovative approaches, sensitive processes and participatory institutional arrangements and linkages at all levels.

Entering the community: Social Mobilisation and Community Participation in Community Health Worker Programmes

Informed and involved communities can have a major impact on health practices and outcomes. Community participation in health care is extremely important, especially in countries such as India, where though the outreach of the existing health system is wide it has not ensured adequate impact.[6] The country's high levels of mortality and morbidity reflect a context within which the majority of people possess neither the 'goods' for health maintenance (adequate food, clean and abundant water, financial resources and most importantly awareness and knowledge), nor have access to quality services that would decrease the severity and improve outcomes of illness.[7] Most importantly, many of the actions and interventions with the highest potential to save the lives of young children and prevent the onset of malnutrition can and need to be delivered at the community level.[8] It is within this context that developing effective ways to involve communities in designing and implementing community based programmes becomes especially important. However, if community participation aims to combat exclusion,

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[6] India has a national Infant Mortality Rate of 67 per 1000 live births and a Neonatal Mortality Rate of 44 per 1000 live births. India has the third highest Maternal Mortality Rate in the world at 407 per 100000 women (WHO, 'World Health Report 2005).

[7] The formulation of health goods and services is taken from Chatterjee Meera, Implementing Health Policy, Centre for Policy Research, Delhi (1988)

[8] The importance of community-based interventions has been comprehensively covered in the *Lancet Child Survival Series* (2003, Vols. 361 and 361; www.thelancet.com)

empower people regarding their own health, mobilise community resources and ensure ownership and sustainability of programmes, then conscious efforts at social mobilisation and meaningful community engagement need to undertaken from the inception of any programme.

The CHW is envisaged as an agent of knowledge on health and nutritional issues, as well as preventive and referral guidance, and in the longer term as a grassroots organiser of the community around their health needs and rights, especially involving women and weaker sections of the community. The CHW is also expected through her activities to help improve the utilisation of essential health services and undertake local level advocacy and spur collective action for equitable access to these health services. For the CHW to be effective within her community, the community must not view her as an external entity but internalise the need for her and own their role in creating and sustaining hers. It is therefore extremely critical that she be selected after a phase of social mobilisation that clearly communicates the rationale for CHWs to the community. This phase is also critical in discussing with the community her roles, her accountability and most importantly involving them in her support and sustainability.

Processes of Social Mobilisation

Community participation and social mobilisation for CHW programmes has taken a range of forms aiming to create awareness about community health needs and rights. These activities serve as catalysts for initiating a process of dialogue and rationalisation with the community regarding the need to have their own health worker. Social mobilisation in the context of CHW programmes therefore addresses issues of selection, profile and sustainability of a health worker placed within the community. Indeed, it is a critical pre-selection activity and can have an impact on the existence and sustainability of the programme. This phase not only sets the tone for long-term support to a CHW programme, but also is also important in facilitating the community in taking a stake in this process.

Different CHW programmes have innovated with a range of social mobilisation processes and activities. This has been done through intensive interactions with community members and village leaders, undertaking participatory village mapping exercises and consultations, and through the formation of self help groups, women's groups, village health committees, and other collectives. Undertaking such processes not only creates

community ownership of the CHW programme but also generates a degree of awareness regarding the health and nutritional concerns of the community.

Programme planners have also noted that when the CHW is perceived as a representative of a people's health movement, her positioning and responsibility within the community is constructed differently from when she is perceived as another, lower level functionary of the government public health system. It is with this in mind that the state-wide Mitanin Programme in Chhattisgarh sought to create a strong social mobilisation phase, building on local cultures and popular media to engage communities. This Programme actively involved local theatre groups, who travelled from village to village, raising community awareness regarding health rights as well as the need for demanding quality services from the public health system. Against this backdrop, they introduced rural communities across the state to the Mitanin Programme and to the concept of the CHW as central in facilitating change [9]

Facilitation and Selection of the CHW

Facilitating the selection of a CHW from within a community is an extremely important part of designing a community health programme and ensuring its acceptability, quality and sustainability. Creating a space for such a worker or volunteer – within the community, within the programme, and within the public health system – requires flexibility to both community and individual needs, as well as commitment to providing continuous inputs and supportive structures.[10] Her selection needs to be facilitated in a manner that is not entrenched within village dynamics, politics and discrimination, while ensuring that she does not become viewed as an appointed low level fieldworker on behalf of government systems. In the context of India, where there is immense political, cultural, religious and caste heterogeneity, the facilitation process for a CHW needs to address and understand village and community dynamics and power relations before the final selection takes place.

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[9] Biraj Patnaik shared this perspective in a presentation on the planning and development of the Mitanin Programme in Chhattisgarh at a Workshop organised by the Social Initiatives Group in Mumbai in March 2003. The importance of social mobilisation in the Mitanin Programme is further described in a State Health Resource Centre Publication, *The Mitanin Programme: Conceptual Issues and Operational Guidelines*, Raipur (2003)

[10] Social Initiatives Group, Key Health Workers and Village Health Committees in Jharkhand: March 2004 Workshop Report (unpublished document)

Poor selection can jeopardise the programme, especially its central aims of equity and inclusion, from the very inception. For instance, in certain blocks where the Integrated Child Development Services (ICDS) attempted to select the Anganwadi Worker (AWW) from the community, it was found that many AWWs belonged to either families of members of the local governance council or belonged to an upper or powerful caste in the village. [11] The nomination of workers from a higher caste or influential class marginalises the lower castes and poorer members of the community and does not address their problems in the process. Another study undertaken on CHWs in tribal areas of Madhya Pradesh found that the programme treated the entire rural population 'as one homogenous mass without taking into account the reality of social classes and their dynamics'. As a result, poorer people, who needed the CHW most, were treated casually and without dignity, and were excluded from all significant decision-making processes regarding the scheme. Instead, relatively privileged residents benefited most from the CHW's attention and influenced the running of the programme.[12]

Inadequate attention to the selection process also impacts the quality of services provided by the CHW and the long-term future of the programme. The Jan Swasthya Rakshak Scheme in Madhya Pradesh, for instance, undertook a minimal approach to selection and eventually recruited unemployed young men. An external evaluation of this programme found that many of these health workers eventually ended up as 'quacks' and were not accountable to either the community or the system.[13]

Various NGOs and government programmes have innovatively developed selection processes for CHWs in their respective health programmes. The Child in Need Institute (CINI) in West Bengal, for instance, started its programmes by forming village-level Health and Nutrition Committees. The members of these committees acted as change agents in the community and were responsible for introducing the CINI health worker to the village. In a CHW-centred action-research project in rural and tribal blocks of Jharkhand, social mobilisation was first undertaken by project facilitators visiting villages and hamlets a number of times, understanding village caste, class and tribe dynamics, initiating dialogue with important community representatives and the marginalised

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[11] Chatterjee, M & Measham, A. *Wasting Away: The Crises of Malnutrition in India*, World Bank: Delhi (1999)
[12] Study quoted in Mander, Harsh "People's Health in People's Hands?: A Review of Debates and Experiences of Community Health in India" CEDPA: Delhi (2005)
[13] Abhay Shukla presented this experience during a Workshop organised by the Social Initiatives Group in Mumbai on March 2003.

within the community. This then led to the formation of Village Health Committees oriented to the need for a community based health worker. The first activity of the VHC was the selection of a community health volunteer for every hamlet, a process undertaken in consultation with the larger village council (*Gram Sabha*).[14] Earlier, in the pioneering community health initiative in Jamkhed, Maharashtra, CHWs were selected through farmers' clubs, groups that then continued to act as community-based institutions that supervised the CHW along non-technical parameters. As the clubs were involved in hiring the workers, they were also able to change them when they felt it necessary.[15]

In the Mitanin programme, after the extensive social mobilisation campaigns described above, the selection process was initiated by a facilitator who stayed in hamlets for a few days, gaining a more nuanced understanding of community dynamics. The facilitator then involved the residents in the selection of a hamlet-level CHW, consciously guarding against biases of caste and socio-political divisions. The decision to select hamlet-level volunteers was also shaped by considerations of the relatively greater homogeneity of hamlets, therefore enabling greater inclusion and equity.[16]

All of these experiences underscore the importance of a deeply engaged and participatory process of selection of CHWs. Involving communities in the selection process creates a broader democratic base to the CHW initiative, while efforts need to be taken to consciously safeguard the process from being captured by local elites, power politics and vested interests. Introducing the CHW through field based facilitators at forums such as the village health committee further accords importance and recognition to her, thereby adding to the quality of the process. The selection of any worker at the community level is a complex process and needs to be facilitated by people who are able to understand and grasp the caste, class and power dynamics ingrained in the heart of most communities and are therefore facilitators also need to be adequately oriented to the aims and sensitivities of this critical activity.

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[14] The project known as the Ranchi Low Birth Weight Project is a collaborative field research initiative undertaken by the Child In Need Institute, Krishi Gram Vikas Kendra (KGVK) and the Social Initiatives Group of ICICI Bank, in partnership with the Department of Health, Government of Jharkhand.

[15] The Comprehensive Rural Health Project in Jamkhed, Maharashtra initiated by the Aroles is one of the pioneers of CHW programmes in India and internationally.

[16] State Health Resource Centre, Chhattisgarh. Mitanin Programme, Conceptual Issues and Operational Guidelines, SHRC: Raipur (2003)

Qualifications

The profile of a CHW is linked to the role she has been envisaged to play and to her positioning in the community. CHWs are essentially conceptualised as preventive and promotive care workers, and are usually especially engaged in addressing issues of reproductive and child health, including the promotion of family planning practices and nutritional counselling at the individual and household levels. First and foremost, it is critical to understand that she is not a paramedic, not a doctor and not a nurse, but has been conceptualised to address and create community-based and owned health action and awareness, in the process demystifying medical health delivery.[17]

Different CHW programmes have had varying criteria regarding the education levels and literacy backgrounds of the workers. Many have worked with semi – literate and illiterate women as CHWs in their programmes and have been very successful in their impact. Involving women with low levels of literacy does not seem to impede the programme, especially if it focuses on disseminating health knowledge. Many illiterate women are very capable communicators and negotiators; moreover this new role provides them with greater opportunities and confidence than they would otherwise receive.[18] The decision to work and support semi-literate and illiterate CHWs, however, does require the programme to remain continuously conscious of their needs. Training materials and methodologies need to sensitively designed and all activities, including field registers, kits and technologies need to be creatively adapted and made accessible.[19] If well supported though, this decision could eventually contribute to creating a women's empowerment movement, where semi-literate or illiterate women emerge at the forefront of their communities and its health.

Ultimately, especially when some form of community selection is involved, it is important to recognise and trust that community members are generally in the best

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[17] David Sanders and others have viewed the CHW as a mode of demystifying medicine and health. Sanders, David, "The Medicalisation of Healthcare and the Challenge of Health for All", Background Paper #3, People's Health Assembly (2002)

[18] A number of programme experiences, including those of the Foundation for Research in Community Health (FRCH) in Maharashtra, SEARCH in Gadhchiroli in tribal Maharashtra, the Ranchi Low Birth Weight Project and the Mitanin Programme in Chhattisgarh have been able to work with semi-literate and illiterate CHWs.

[19] Among NGOs, CEHAT has especially innovated on preparing materials for illiterate CHWs. The Mitanin Programme also had to adapt its teaching materials and learning aids, as well as use illustrations on the drug kits. The Ranchi Low Birth Weight Project has developed an accessible colour-coded cohort register for field use by the CHWs.

position to understand which woman from among them is likely to be most able to contribute time and effort towards such work. For instance, they are likely to take her age, family life, as well as interest in community issues into consideration in their decision to select their CHW. A community may prefer a daughter-in-law to a daughter, since the former is more likely to remain in the village. Similarly, an older mother may be preferred since she will have to devote less time to early childcare. The very poorest are unlikely to be selected for voluntary positions taking into account livelihood needs. As various programmes demonstrate, however, even unmarried women, young mothers with little children, and old women around 45 to 50 years of age can do this work with great enthusiasm, as long as they receive support from their families and communities.[20] Many of the traits that make a good CHW – such as their personal commitment, life experiences, and family contexts – are often missed by enforcing literacy levels and age limits – but are subtly woven into community thought processes as they choose their CHWs.

Training

The quality of training is the most crucial determinant of a CHW's effectiveness in serving her community's health needs. It is equally a determinant of the overall success of any CHW programme, no matter the scale. It is within the training component that the quality of the CHW's work, her credibility, her interest, her communication skills and most importantly, her confidence gets established.

Training content for CHWs vary widely, ranging from conveying knowledge and communication skills to enable them work as BCC agents on nutritional and food practices, early child care, general hygiene, health seeking behaviour, and women's empowerment to providing them with more technical skills on birth asphyxia[21] and newborn care[22], and

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[20] The sheer range of CHWs that have been selected in rural blocks across Jharkhand and Chhattisgarh illustrate this point well.
[21] The Tribhuvandas Foundation working in rural Gujarat trained their village health workers to address neo-natal birth asphyxia.
[22] The SEARCH Project in Gadhchiroli in rural Maharashtra focused its trainings on newborn care interventions, including the management of neonatal sepsis and birth asphyxia.

the administration of common drugs[23] Some programmes have even added a component of veterinary care and services as part of CHW training.[24]

Training modules for CHWs need to judiciously and accessibly balance technical knowledge within social contexts, with a continuous focus on community based counseling (BCC) and effective interpersonal communication skills. As a CHW's effectiveness depends on household and community level interactions and her response to everyday events as they unfold in the villages, CHW training modules tend to have a better impact when an aspect of field-based training is also incorporated. This provides the CHW with greater confidence in her knowledge through an ability to assess issues in her community context rather than in the environment of a training centre. Training conducted in a phased manner has also been found to be more effective than a one-shot training. Phased training ensures time for revising basic concepts and does not load the individual with too much new information all at once. Some CHW experiences have also emphasized the need to build in continued on job training for CHWs, once the initial phases of training have been completed. This is specifically useful in building confidence in CHWs and also helping them revise their knowledge of health issues.

Creating suitable training teams is another critical aspect of the CHW programme. In smaller scale initiatives, training is usually undertaken by teams consisting of those who had facilitated the CHW programme in the region, including by doctors, health trainers, social workers and social scientists, but often these high quality and intensive resources are hard to find in large-scale initiatives. In government programmes it has been observed that having only the public health system doctors imparting the training made it too technical and medicalised and overlooked issues of preventive, promotive and community health. [25] Therefore some initiatives operationalised through public health departments choose to invest in recruiting new trainers as part of the training teams, often along with the existing staff of the health department, which included doctors, Auxiliary Nurse-Midwives (ANMs) and Lady Health Volunteers (LHVs).[26] It is important to consti-

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[23] The Mitanin Programme has introduced a basic drug kit for the Mitanins and includes a round of training in its use.

[24] The CHWs of the Foundation for Research in Community Health (FRCH) working in rural Maharashtra represent a comprehensive community development approach to training, including aspects of veterinary care and poultry immunisation.

[25] In the Jan Swasthya Rakshak Scheme in Madhya Pradesh only PHC doctors were deployed to form training teams and this was seen to have created a focus on curative care rather than preventive, promotive care amongst the CHWs.

[26] NGO field workers and new community recruits have been utilised by the Mitanin Programme for undertaking initial and ongoing training for the CHWs in the programme.

tute training teams combining trainers representing different backgrounds – medical and non-medical – as this brings a range of perspectives and addresses different dimensions of the CHW's role. In some NGO programmes as well as in large-scale efforts, more experienced CHWs have been found to be particularly good trainers.[27] Similarly, educational interchanges between CHW s from different programmes also act as a forum for learning during the training period.[28]

In large-scale programmes, where 'training pyramids' have been created to train CHWs, it is important to address the issue of 'transmission losses' and hold very strong training sessions (high voltage) at the 'senior' levels. In some cases, fixed modules and standard text books have also been found to be useful for quality and standardisation.[29] At the district and block levels, however, trainers should also be allowed and supported to innovate and incorporate local health issues and practices into their training sessions, addressing them within the frames of regional variations of ethnicity, tribe, religion and caste especially in the use of case studies and examples. Investing in a strong group of master trainers is essential to the success of a programme.

Training techniques need to be innovative and methodologically grounded in the principles of adult learning. As most CHWs could be from illiterate and semi literate backgrounds, it is important to carefully understand and address learning competencies, balancing the need to be accessible while remaining analytical. A CHW requires a combination of knowledge, skills and attitudes to carry out her role effectively and therefore perspective and confidence building are as critical as the retention of key facts.[30] Training methodologies should include elaborate explanation of the training modules and wherever possible deploy innovative techniques such as story telling, skits, role play and puppets etc.[31] Pioneering programmes have invested in generating innovative, context-

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[27] The Foundation for Research in Community Health (FRCH) has very successfully incorporated experienced CHWs into their training teams. In Chhattisgarh, a number of experienced and enthusiastic Mitanins are now performing roles as trainers in the field.

[28] Numerous programmes have sent CHWs and facilitators to visit the FRCH site in Parinche, for instance. Seeing CHWs in action and learning from them can be inspiring for new CHWs and orient their trainers and facilitators to field realities and challenges.

[29] SHRC, Chhattisgarh, "Training Strategy" in *The Mitanin Programme, Conceptual Issues and Operational Guidelines,* SHRC: Raipur (2003)

[30] Ibid.

[31] For a perspective on the use of innovative regional and local innovations in training drawing especially on the Project Piaxtla in Mexico, see Werner, David, "Communication as if People Mattered: Adapting health promotion and social action to the global imbalances of the 21st Century" Background Paper #5, for the People's Health Assembly, December, 2002.

specific and mixed-media training materials, which CHWs can keep and continuously refer to.

Taken as a whole, the training process should be conceptualised as part of a process of empowerment. Training strategies should aim to integrate the dissemination of a common body of knowledge within the social and cultural contexts of different regions.

Support and Sustainability

The effectiveness and sustainability of any CHW programme is intrinsically linked to the support it receives from the public health system and the communities it serves. Community-based support and systemic support form an important equilibrium for a CHW programme and provide different kinds of resources that CHWs constantly draw upon and creatively combine in their daily roles. The forms that the interactions between the health system, the local community and the CHW need to be carefully considered across the various conceptual and operational dimensions of the programme, from selection to ongoing support.

Community-based Support

A CHW performs a variety of health activities, linking people in communities to health knowledge, health technologies, and health services. She acts as the first point of contact for the health needs of an individual, household or community and seeks to bridge the gap between the potential for health and its realisation. [32] Many programmes have approached the CHW concept through a broad perspective of health rights, from which the CHW emerges as an important representative of community needs. As previously emphasised, community participation has been understood as a process that works at combating exclusion, empowering people, mobilising resources and energy, developing holistic and integrated approaches and ensuring ownership and sustainability of programmes in achieving effective implementation.

Therefore, building a broad-based and meaningful role for community participation and input within a CHW programme is crucial in ensuring its impact and sustainability. Rather

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[32] Joint Learning Initiative/Global Health Trust. *Human resources for health: overcoming the crisis*. Harvard University Press: Cambridge (2004).

than assuming that community engagement will be an inevitable outcome of placing a CHW in the village, programmes need to create well-defined (but creative and responsive) processes and structures to facilitate community participation and invest both time and resources in strengthening these. As mentioned above, different CHW initiatives have innovated with a variety of forms of community based support in CHW programmes. This has ranged from mother's groups, women's collectives, village health committees, self help groups[33], dairy co-operatives[34] and farmers clubs. Not only can these community-based groups play a vital role in her selection and ongoing activities, they also provide a supportive environment for the CHW to work, create a platform for the dissemination and discussion of health knowledge within the community and generate a greater and more organised pressure on public health providers to deliver services. As much as a CHW requires community support, she often also creates a space for a community-based counterbalance, for empowered with new knowledge and skills the CHW too, especially with experience, becomes another power centre.[35] Close links to a participatory community group provides a potentially important way of ensuring greater accountability to and representation of community needs.

Field-level Convergence and Community-based Information Systems

The relationship between the CHW and frontline health system functionaries – especially the ANM and the Anganwadi Worker – is critical to the quality and accountability of a CHW programme and to the credibility of the CHW. As one of the central roles of the CHW is to act as a link between the public health system and the community, it is very important that the systemic functionaries recognise and respect her and her work and respond in ways that facilitate her activities. Routine events such as immunisation camps and Health and Nutrition Days provide useful opportunities for coordination and mutual support.

Furthermore, a creative community-based management information system (MIS) and feedback process can further enable planning and participation in health service delivery at the field level. For instance, an action-research project in rural Jharkhand has developed an innovative MIS using a very simple, pictorial and colour-coded cohort

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[33] The Tamil Nadu Science Forum's Arogya Iyakkam programme has innovated on the linkages between self help groups at CHWs.
[34] The Tribhuvandas Foundation linked their CHW programme to the local dairy cooperatives.
[35] Personal conversation with Dr. Nerges Mistry of FRCH.

register,[36] adapted to the needs of semi-literate CHWs. The cohort register serves two important functions. It facilitates the health activist's work in the community, helping her organise activities, track cases and analyse outcomes, while requiring limited time. It also provides a medium for sharing information on health outcomes and activities with the community, the AWW and the ANM on a regular basis.

Monthly cluster meetings (at the sub centre level) also provide excellent opportunities for feedback, discussion and analysis, bringing together CHWs, ANMs, AWWs, and leaders of community groups. Such forums create a common learning situation, offering a space for refreshing knowledge and sharing ideas, while ensuring that the different data systems are convergent and complementary. A further innovation is the compilation of a village ranking tool, based on the cohort register data, which serves as a powerful communication tool for the community and generates a sense of purpose and motivation. It is critical that such processes emphasise collaborative analysis and problem solving, thereby promoting a sustainable and friendly model of community health.

Catalysing Health Systems Involvement and Reform

Field-level convergence, however, is largely dependent on the overall public health system responding to the community health worker programme in two interrelated and mutually reinforcing ways. First by orienting itself to actively engage in the conceptualisation, planning and implementation of the initiative and second by simultaneously addressing critical gaps – infrastructural and human resource-related – in the delivery of primary health care and referral services for these populations. The first dimension involves mobilising existing health system personnel to start thinking about the concept of the CHW, her role and their part in supporting her. Rather than accepting the CHW as a scheme to implemented, health department staff should be encouraged to articulate and analyse their expectations and concerns from the early stages of the design. The second aspect necessitates committing resources and implementation capacity on a priority basis to ensure the presence of quality health services for which there will now be greater outreach and demand.

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[36] CINI first experimented by introducing simple, pictorial, colour-coded cohort registers to their CHWs, which aided them in mapping and tracking a woman's pregnancy and her child's growth.

It is vital that all levels of the public health department be oriented and sensitised to the introduction of a community-based health worker, emphasising at all times her accountability to her community rather than viewing her role as an extension service to the health system. These dialogues should take place at the state, district and block levels, seeking inputs and involvement in programme design and implementation while constantly reinforcing the need for a facilitative rather than directive response from system functionaries.[37] Efforts at orienting and engaging different levels of health system staff need to be particularly carefully balanced, negotiating a process where the community health programme does not seem like a parallel effort on the one hand, or business as usual on the other.

While the health system needs to prepare itself to engage in community processes intended to directly impact preventive and promotive care and health seeking behaviour, an appropriately timed and resourced plan to strengthen health service delivery points must be an integral part of the programme. This, as has been noted, is often the weakest aspect of large-scale CHW initiatives, which have to depend on the public health system for services such as immunisation and referral support.[38] Therefore, locating the CHW programme within a larger health reforms process such as the proposed NRHM provides an important opportunity to link community-based and systemic change. To do so, however, would require implementing the CHW programme and a minimum set of measures to upgrade primary healthcare facilities and staff skills in a simultaneous and interrelated operational plan. While the health reforms agenda in India is clearly extensive, including the need for policy changes in financial allocation and human resources capacity building, it is imperative to develop a package of interventions to upgrade health infrastructure at the Sub Centre, PHC and CHC levels, ensure the supply of basic drugs and vaccines, provide the basic equipment for antenatal check-ups, delivery and post natal care, and urgently fill vacant posts with the appropriate paramedical and medical staff.[39] In the context of the NRHM priority states, where public

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[37] The state government of Jharkhand undertook such a process, convening a series of participatory workshops during the design phase of their CHW programme, where a mix of public health functionaries actively contributed to the conceptualisation of the initiative. Through facilitated discussions with civil society innovators and activists, these were important forums for orientation, perspective building and ownership.

[38] Mander, Harsh. "People's Health in People's Hands?: A Review of Debates and Experiences of Community Health in India" CEDPA: Delhi (2005)

[39] The State Health Resource Centre in Chhattisgarh has undertaken a review and analysis of different aspects of health systems strengthening for that state. Unfortunately, these reforms were not implemented at the same time as the Mitanin Programme was rolled out. See SHRC, *Strengthening Public Health Systems: Report of a Study on Issues of Workforce Management,*

health system performance is exceedingly poor it will be difficult for this process to occur across the state within a short span of time. To ensure a linkage, therefore, a phased implementation should be undertaken in which blocks are selected for *both* health systems upgradation and the introduction of the CHW. This is not only vital from the perspective of supporting and validating the CHW's role in improving outreach and access, but an opportunity to encourage community participation in health systems strengthening. Initial experiences from an ongoing field project in Jharkhand, for instance, are demonstrating how village health committees organise themselves to contribute collectively, either monetarily but more often with their labour or even community land to sub-centre construction, renovation and maintenance. Moreover, when these activities were undertaken soon after committee formation, it served to facilitate the process of strengthening the committee by providing a platform for collective action, while improving the ANM's working conditions and in some cases her living quarters.[40] These early examples of mutuality, community investment and participation in health service delivery will hopefully lead to sustained improvements in health service performance and utilisation, as well as developing mechanisms for community-based monitoring and accountability.

Valuing the CHW: Incentives and Motivation

The issue of incentives is among the most controversial aspects of CHW programmes and inevitably seems to revolve around debates between volunteerism and paid employment. While this is undoubtedly an important debate, a narrow monetary approach to incentives raises its own set of problems and all too often detracts attention from other creative and multifaceted approaches to the central challenge of motivating and sustaining CHWs in poor communities.

The main criticism against mobilising volunteers as CHWs, especially in large-scale government programmes such as the ASHA scheme of the NRHM is that is a form of exploitation, especially as it claims the time and energies of poor women and their households. While there is no denying the difficult social and economic circumstances that most CHWs must contend with on a daily basis, small salaries, stipends or honoraria

Rationalisation of Services and Human Resource Development in the Public Systems of Chhattisgarh State. SHRC Working Paper 3: Raipur: 2003.
[40] Personal conversations with the Ranchi Low Birth Weight Project team and visits to the project field area.

however are not necessarily the best ways to address this problem. There are a number of reasons for this. First, the anticipation of even small sums of money from the government creates expectations that often compromise and politicise the selections process and continuously raises demands for secure government employment, a response that is extremely unlikely to materialise. It also transfers a sense of the CHW's accountability away from the community to the government, who may view the CHW as an agent of the health system instead of a representative of community needs. Second, the amounts provided in such salaries and stipends are usually low, leading to constant comparison and dissatisfaction between various frontline service providers. Thirdly, large-scale programmes are very often unable to disburse payments on a routine and reliable basis to so many field functionaries, which tends to be very de-motivating and distressing for expectant CHWs.[41]

These reasons, however, do not in any way imply that a reliance on volunteerism is an easy alternative. Indeed, it only demands a much more creative and continuous approach to the challenge of motivation and accountability. To begin with, volunteer-based CHW programmes must first and foremost respect livelihood needs and ensure that the roles expected of CHWs are very reasonable and flexible. They must also be committed to compensating losses to wages that may have been earned and cover expenses incurred on days spent on programme activities such as training and cluster meetings. In addition to this basic requirement, activity-based incentives may also be tried out with the caveat that this sometimes creates a bias towards certain kinds of work (especially drug dispensation and curative care), can introduce a sense of targets (all too familiar in the family planning experience), and lead to disappointment and frustration if the cash transfers are not reliably disbursed. Another approach is for CHW programmes consider a range of cash and in-kind incentives delivered through community-based structures and linked to specific activities. There have been numerous innovative efforts in this regard where community members have compensated CHWs in-kind through food, housing, agricultural assistance, or childcare and schooling support for their children. Community-based fund collection and financing mechanisms, such as Village Health funds may also be allocated towards supporting the CHW. Similarly, government systems have a number of options for non-financial incentives that although small

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[41] For a very useful discussion and review of international experiences on this issue, see Bhattacharyya, K et al "Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention and Sustainability" Published by the Basic Support for Institutionalising Child Survival Project (BASICS II), USAID, Arlington, VA (2001). www.basics.org

provide significant forms of recognition and respect, including identity cards, bags, recognition at special events like national days, simple items such as dishes and utensils for the home, and plants and seeds for kitchen gardens among others. The programme could also explore means of supporting CHWs in income generating activities, access to micro credit and insurance for them and their families, and enrolment in literacy classes and vocational training courses.[42] Longer term plans for personal development and career ladders for highly motivated and well performing CHWs, including building them into effective trainers could also be integrated within programme plans.

Ultimately, however, motivation levels among CHWs are a result of a number of tangible and intangible elements and represent the overall programmatic environment, especially the critical relationships between CHWs, their communities and the health system. It is intimately related to their status and confidence, which in turn hinges on the sensitivity and quality of the processes outlined above, from social mobilisation and selection to learning through training and supportive supervision, and its translation through active engagement from community groups, and collaborative interactions with health providers. Programmes should therefore take a multidimensional approach to the question of incentives for CHWs and explore a mix of options and strategies to continuously build up a culture of support and motivation.

Enabling Institutions

Integrating the critical elements of a community health worker programme described above into large-scale initiatives, such as those proposed under the National Rural Health Mission, require participation and ownership by a range of actors and institutions engaged in different kinds of partnerships. Most importantly, these relationships need to be formed with the recognition that community health workers are not an independent and additional intervention strategy, but part of a longer-term *process* of community-based change and health systems strengthening. From this perspective, CHW programmes provide states with an opportunity to initiate a participatory reforms process that is responsive to context-specific realities and institute an active action-research system engaging local communities, all levels of health department

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[42] Ibid

functionaries, civil society actors, funders and private sector institutions. Broad-based involvement at the state-level, from government departments (Health, Women and Child Development, Panchayati Raj, Rural Development), NGOs, regional academic institutions, as well as funding agencies therefore needs to be encouraged by open consultations and appropriate platforms for sustained dialogue and coordinated efforts. Through multi-sectoral discussions, state-specific institutional arrangements need to be developed, which effectively integrate diverse resources without fragmenting the system and work to ensure continuous guidance and troubleshooting from the state-level while enabling decentralised planning and implementation within districts, blocks and villages.

Evolving Resource Support Structures and Partnerships

While state health departments will be called upon to play leading roles in the implementation of the NRHM and the ASHA programme, the mission also creates space for evolving innovative public-private partnerships with non-governmental organisations and other private sector actors. Community health worker programmes, as has been emphasised throughout this paper continuously combine and integrate aspects of community-based action and public health services and therefore invite participation from a range of state and non-state actors and institutions. Enabling their involvement in planning, capacity building and implementation requires evolving innovative institutional arrangements and structures. These structures, however, must be carefully balanced to ensure that the arrangements are not purely contractual in nature, where NGOs simply implement the programme on behalf of the government in different regions, or institute a parallel system that fails to integrate and strengthen the existing one without replacing it. On the other hand, a well-facilitated partnership-building process could make the most of diverse state-based and local institutions, leveraging expertise and experience through a dynamic and decentralised resource support system.

NGOs, local colleges and teaching institutions, as well as management and research facilities can play innovative and important roles in strengthening a large-scale CHW initiative. NGOs can be identified both as implementation partners in certain geographies and on the basis of the technical expertise that they could provide programmatic inputs especially in areas such as community-based planning, behaviour change communication and training. In addition, both public and private clinical facilities are also being integrated within the programme to provide teaching and learning environments

for systemic functionaries and community activists. Moreover, institutes for management and education can add another set of skills and expertise to the initiative.[43]

Processes and platforms need to be developed by structuring the participation of this diverse range of actors in the form of resource centres, not only at the state level but also at regional and district levels. Rather than imagining these as cumbersome new structures, it would be more useful to conceptualise them as dynamic cells of expertise and innovation potentially housed within existing institutions, attached to NGO field sites and district hospitals, with their resource persons supporting and catalysing planning and service provision within CHCs, PHCs, Sub Centres and within villages. These resource centres, then, would have the capacity to contextualise operational guidelines and modules to regional and local realities. Local facilitators could be positioned to initiate processes of formative research with communities to create context-specific behaviour change communication strategies and adapt training materials to the linguistic and ethnic systems practiced in particular regions. While these centres will be supported by a state-level technical unit, a key feature of the resource support structure should be its ability to respond contextually and to identify talented local resource persons – both from the public health system and from non-state institutions. Each resource centre could also directly manage a field site, which could pilot innovative methodologies and responsive interventions before integrating these into wider district and regional programmes. These sites could then form a network of field learning and practice sites and take responsibility for organising visits and forums for sharing experiences and innovation.

CHW programmes are essentially about enabling capacity building within communities and health systems and can be visualised as catalysing and sustaining processes of health development.[44] An interactive resource support structure therefore has the potential to impact both the quality of community-based interventions of social mobilisation and training *and* serve to sensitise health systems functionaries by involving

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[43] The Mitanin Programme is Chhattisgarh implemented through the State Health Resource Centre has developed a range of partnership arrangements across the state, drawing on existing movements and civil society organisations in different blocks. These kinds of partnerships were also being actively explored as part of the Sahiyya (CHW) Programme in Jharkhand, where the Xavier Labour Relations Institute (XLRI) and Institute for Tribal Education were also closely associated with development of the initiative

[44] Lehmann, Uta et al, "Review of the Utilisation and Effectiveness of Community Health Workers in Africa" Joint Learning Initiative (2004).

them in the learning process. Involving the staff and students of hospitals, health centres and teaching institutions in resource activities can in turn influence their attitudes towards community needs and realities and gradually improve the quality of service provision.

While a number of NGOs are well positioned to undertake such resource support activities, they must also contend with their own resource-constraints and are challenged to adapt their existing structures to respond to the demands of government programming and timelines. Their own staffs, therefore, requires a process of engagement and orientation to take up these new roles and manage the relationships emerging between communities and health service providers. Given the potential of initiating such multi-sector partnerships, it would be beneficial if funding agencies consider investments in building the state's existing non-governmental resource and expertise base as part of their overall programmatic support. This would enable state and regional level interdisciplinary teams with clinical, health systems and community mobilisation experience to coalesce and contribute to the CHW initiative on a sustained basis.

Developing a Participatory and Dynamic Action-Research System

A strong community health worker programme, implemented through decentralised and responsive systems and structures, will facilitate the creation of an action-research environment. The resource support structures described above, for example, would have in-built systems to collect, analyse and integrate field-based data and knowledge into intervention strategies and training methodologies. However, CHW programmes also provide an important opportunity to embed more formal research studies and generate a number of research areas that are crucial to strengthening the programme and contributing to long-term health development. These can be categorised under three broad and interrelated kinds of questions: 1) health impacts; 2) process-related issues and operations research; and 3) institutional reform and development.

In addition to a continuous monitoring system and the frequent analysis of MIS data, a more detailed investigation of field realities, health needs and community responses can be developed through the integration of a number of rigorous research sites. Such sites could potentially be located within the resource centres field areas, where the staff could

be specifically oriented, trained and supported along with research partners to conduct and manage complex community-based research studies. A phased rollout of the programme, moreover, could provide an opportunity to compare intervention and control areas prospectively and in different stages of 'exposure' over a period of time. These research studies must be carefully designed to engage the community and health system functionaries in the research process, not only in data collection, but also in analysis and dissemination. Good quality data on certain parameters, such as birth weight, for instance, may be difficult to initially collect across the state and therefore may be picked up and analysed in a sample of blocks on a regular basis. In addition, innovative training methodologies and BCC materials and more intensive technical interventions, such as the home-based management of neonates or malnourished infants, can also be studied in detail, measured and adapted before being integrated within the larger programme. Both quantitative analyses and ethnographic and other qualitative data would also help develop an understanding of how communities, CHWs and health providers are responding and generate analyses of how the programme is performing in terms of the coverage, quality, cost-effectiveness and sustainability of its key processes. As with the resource support structures, the research system should also prioritise capacity building, training community members and programme facilitators to participate in the research process. If possible, local students from technical colleges and institutions could also participate in research projects, providing human resources for data collection and analysis while building their knowledge and skills base.

Along with such participatory community-based research studies, the institutional arrangements and multi-sector partnerships involved in implementing the CHW programme offer a different kind of research site within which to study the dynamics of institutional reform and health systems development. This will require building on methodologies to understand organisational behaviour and reforms processes and provide learnings on effective partnerships, systems and human resource development. These findings could then provide the basis for strengthening training programmes for civil servants, health professionals and NGOs on an ongoing basis.

Research is an integral part of public health reform and development and should therefore be built into the programme's resource plan. As complex public health undertakings, combining technical, social and political dimensions, large-scale CHW

programmes must remain dynamic and responsive learning environments, integrating innovation and evaluation in every phase of their evolution.

References

Antia N.H. & Bhatia K. *People's Health in People's Hands; A model for Panchayati Raj*, FRCH: Pune (1993)

The Bellagio Child Survival Study Group. *Child Survival Series* in *The Lancet,* Volumes 361 and 362 (2003)

Bhattacharyya, K et al. "Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention and Sustainability" Published by the Basic Support for Institutionalising Child Survival Project (BASICS II), USAID, Arlington, VA (2001) www.basics.org

Chatterjee, Meera. *Implementing Health Policy*, Centre for Policy Research: Delhi (1988)

Chatterjee, M & Measham, A. *Wasting Away: The Crises of Malnutrition in India*, World Bank: Delhi (1999)

Joint learning initiative/Global Health Trust. *Human resources for health: overcoming the crisis*. Harvard University Press: Cambridge (2004).

(http://www.globalhealthtrust.org/JLI.htm)

Lehmann, Uta et al. "Review of the Utilisation and Effectiveness of Community Health Workers in Africa" Joint Learning Initiative (2004)

Mander, Harsh. "People's Health in People's Hands?: A Review of Debates and Experiences of Community Health in India" CEDPA: Delhi (2005)

Sanders, David. "The Medicalisation of Healthcare and the Challenge of Health for All", Background Paper #3, People's Health Assembly (2002)

Social Initiatives Group. Key Health Workers and Village Health Committees in Jharkhand: March 2004 Workshop Report (unpublished document)

State Health Resource Centre, Chhattisgarh. *Strengthening Public Health Systems: Report of a Study on Issues of Workforce Management, Rationalisation of Services and Human Resource Development in the Public Systems of Chhattisgarh State.* SHRC Working Paper 3: Raipur: 2003.

State Health Resource Centre, Chhattisgarh. *Mitanin Programme, Conceptual Issues and Operational Guidelines*, SHRC: Raipur (2003)

Tontisirin, Kraisid and Gillespie, Stuart. "Linking Community Based Programmes and Service Delivery for Improving Maternal and Child Nutrition" in *Asian Development Review*, vol. 17, nos. 1,2, pp 33-65 (1999).

Werner, David, "The Village Health Worker: Lackey or Liberator" First published in 1977. http://www.healthwrights.org/articles/lackey_or_liberator.htm

Werner, David. "Communication as if People Mattered: Adapting health promotion and social action to the global imbalances of the 21st Century" Background Paper #5, for the People's Health Assembly, December, 2002.

World Health Organisation (WHO). *Strengthening the performance of community health workers in primary healthcare: Report of a WHO Study Group*. WHO Technical Report Series 780. Geneva: 1989.

World Health Organisation (WHO) *World Health Report*, Geneva: 2005