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ROLE OF COMMUNITY HEALTH WORKERS IN THE INDIAN PUBLIC HEALTH SYSTEM

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Abstract:

Over the decades, the community health workers (CHWs) have played a pivotal role in increasing access to health services, especially in a low-middle income country like India which has a less resilient health system. Despite the higher risk of community spread of COVID-19, Community Health Workers (CHWs) had to deal with the patients & community regularly to update information about community health. This paper focuses on the significance of CHWs in the Indian Public Health System. The primary data collected from 167 Women respondents through Questionnaire, and analysed data through various statistical tools.

Keywords: *COVID-19, Community Health Workers, ASHA, Anganawadi workers.*

INTRODUCTION

Healthcare facilities are not only essential but also necessary for human existence and healthy living. The health status of an individual or a member of society mainly depends on the extent of availability, accessibility, affordability, and universality of healthcare services. India's frontline healthcare workers, Accredited Social Health Activists-ASHA were honoured with the global leaders' award- 2022, announced by the world health organisation at its 75th world health assembly on 22 May 2022, for their crucial role in connecting the community and the health system. In India, community-based frontline workers are recognised as ASHA. India has more than one million ASHA workers who are considered lady volunteers in the Indian public health system. (WHO, 2022).

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The public health system across the nation is a conglomeration of all organised activities that prevent disease, prolong life and promote the health and efficiency of its people (Satpathy, 2005). All societies have been making conscious efforts to provide universal health care to all members. There are inter-region differences in the public health system across the country. Article 21 of the constitutional right to health is provided as a fundamental right. It includes the affordability of health care services. The state must make provisions to ensure everyone is getting health care services. (N K Ganguly, 2020).

INDIAN PUBLIC HEALTH SYSTEM

Multiple systems are set up in rural and urban areas of India, including Sub Centres, Primary Health Centres, Community Health Centres, and Government Hospitals at the taluk and district levels. The Indian health system is always dominated by curative services. But present situation, where there are demographical, technological and epidemiological transitions, it is evident that we need to shift the focus more on preventive and promotive health services (N K Ganguly, 2020). It is possible to cater the service to the community through community-based health workers more effectively and efficiently.

COMMUNITY HEALTH WORKERS IN INDIAN PUBLIC HEALTH

As per the NHM-MIS report (2019) there are 10,47,324 *ASHA workers,* 13,02,617 Anganawadi Workers, *and* 53,243 *Anganawadi helpers in the states of India.* ASHAs are honorary volunteers who receive honorariums and incentives. Though they have now become integral to the Indian public health system as community health workers. Anganwadi workers provide maternal and child health services, built into the ICDS scheme in 1975. The National Health Mission started in 2005, initiated ASHA’s flagship programme to engage lady health volunteers to facilitate curative care. Due to their extensive caregiving and health promotion role, they have become integral to the Indian public health system (Bhatia, 2014).

The pandemic crisis was challenging to ensure quality care service in the public health system. Despite the evidence of potential CHWs, they are not integrated into the health system in India. To ensure healthy lives for all at all ages, the deployment of CHWs have identified.

ABOUT ASHA WORKERS

ASHA workers are female community health workers instituted as community-based health functionaries under the National Rural Health Mission (NRHM) launched in 2005. National Urban Health Mission in 2013, it was extended to urban settings. Goa is the only state with no ASHA workers.

LITERATURE REVIEW

Amit Kumar Gupta, (2015) discusses managing public health concerning human resources. The study aims at identifying the Human Resource initiatives in the public health system. The researcher finds out the several challenges that are present in the public health service system related to HR in different states of India. Most states have no public health cadre to resolve these issues. The researcher puts forth his opinion on creating public health cadre on a priority basis for the effective implementation of the National Health Mission.

Marlon Haywood (2017) Identifies community health workers' importance and how their work can be enhanced to strengthen the public health system. The study's objective is to implement the certificate program to give higher education to community health workers. The study found that the certificate program was not aligned with employment goals even though these programs were aimed at the career progression of the CHWs.

Bhatia (2014) this study was conducted in the Shahapur taluka of Maharashtra State, where the ASHA scheme is functional. The study found a high absenteeism rate as it recorded the significant difference of 96 ASHA members during the meetings reported in the records.

Sanjay Zodpey (2021) Propound the idea of transforming the public health system to enhance the community's health services. The study aimed to look at the possible ways to address the challenges with a particular focus on HRH in public health service delivery in India. The researcher observes that instituting a national HRH body, PPP models for HRH, country's HRH ratio, 2.5% of GDP for health expenditure, 25% of assistance to health to HRH, measures to reduce rural-urban distributional disparity in health workers to adopt improve India's public health system.

Lakshmi Gopalakrishnan et al. (2021) the author investigates how supportive supervision affects the performance of community health workers

in India. The study was conducted in 12 districts of India; the study finds that supervision would affect the performance of CHW directly and indirectly through accountability measures and increasing knowledge. The researcher concludes that the management of CHW can enhance performance and contribute to protecting health.

RESEARCH OBJECTIVES

- To assess the contribution of Community Health Workers to Indian Public Health.

RESEARCH METHODOLOGY

The research study is the descriptive research method which describes the significance of community health workers in the Indian public health system through how the health services among women are delivered and whether they are availing the services. To evaluate the significance of CHW's role in the Indian public health system, the primary data is collected from 167 respondents consisting of women from rural and urban areas. The snowball sampling technique is used by circulating the questionnaire, uploaded in the Google form to collect the data among the married women. The secondary data include research articles, journals, books, proceedings, online publications, newspaper articles, website documents, online resources etc. Frequencies, percentages, and cross-tabulation are used to analyse, and the tables are used to represent the same.

RESULT AND DISCUSSION

Table 1: Demographic details of the respondents

Particulars		Frequency	Percent	Valid Percent	Cumulative Percent
Age	18-25	39	23.4	23.4	23.4
	26-35	96	57.5	57.5	80.8
	36-45	21	12.6	12.6	93.4
	46 & above	11	6.6	6.6	100.0
Gender	**Female**	167	100.0	100.0	100.0

Source: Primary data

The demographic details of the respondents are given above. Table 1 shows that 23.4% of respondents are between the 18-25 age group, 57.5% are between the 26-35 age group, 12.6% of respondents are 36-45 age group, and 6.6% are from 46 and above. The data is collected from women Respondents; hence 100% are female.

Fig 1: Educational status of the Respondents

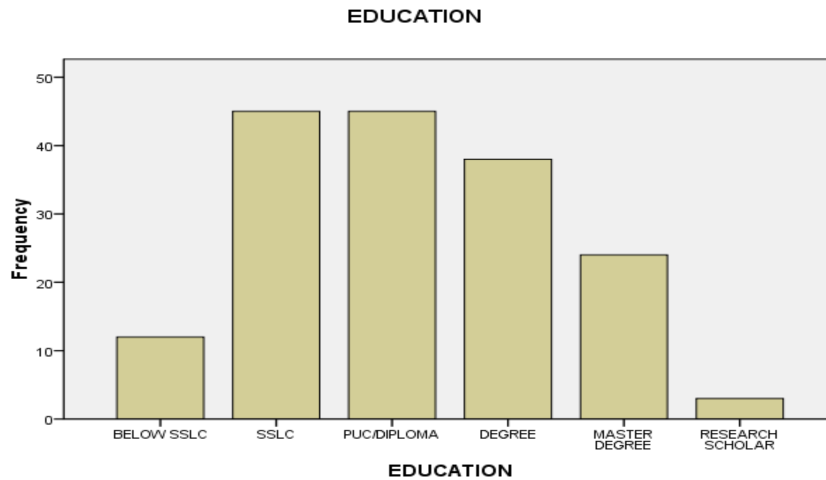

Figure 1 shows the Education status of the respondents 7.2% are below SSLC, 26.9% are SSLC completed, 26.9% are PUC/Diploma equivalent, 22.8% are graduates, 14.4% are postgraduates, and 1.8% are research scholars.

Fig 2: Occupational of the Respondents

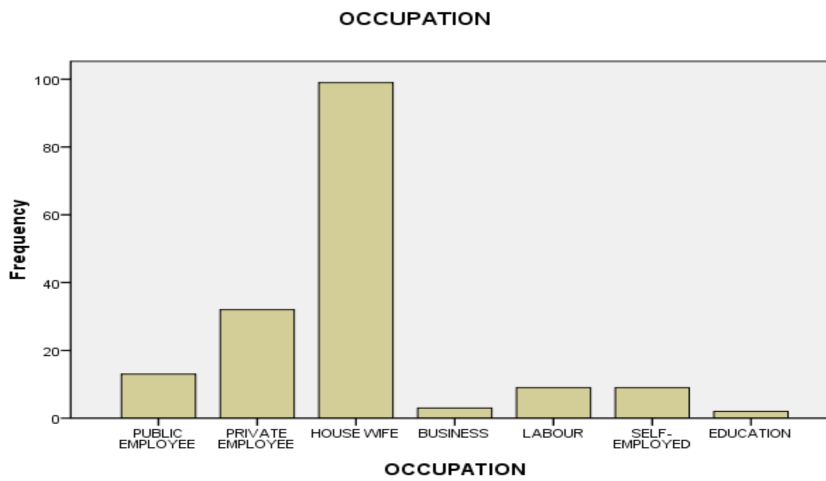

Figure 2 shows the occupation of the respondents, which shows that 7.8% are public employees, 19.2% are private employees, 59.3% are homemakers, 1.8% respondents are doing their own business, 5.4% respondents are labour, 5.4% respondents are self-employed, and 1.2% are doing education.

Fig 3: Districts of the Respondents

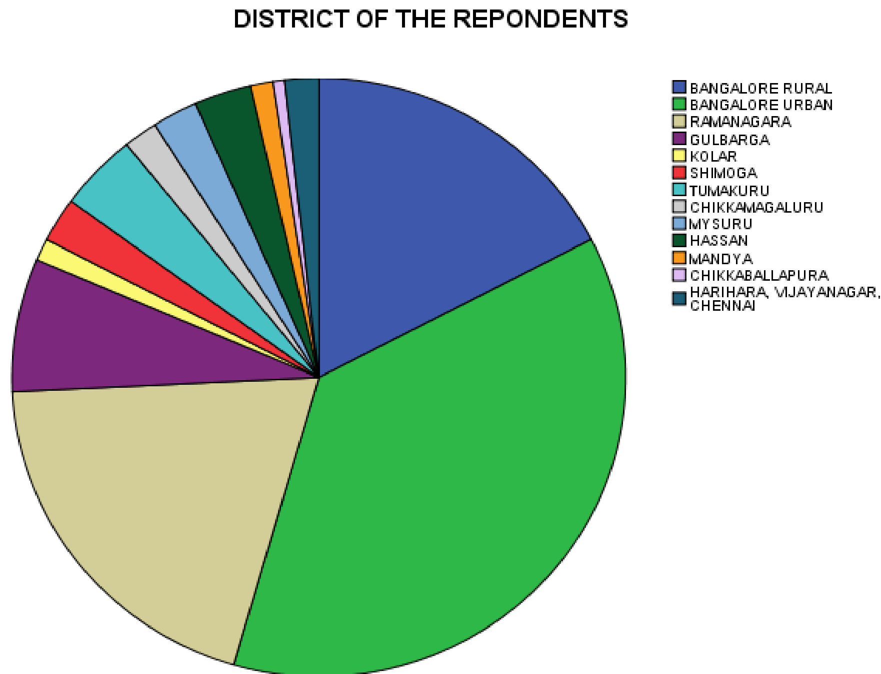

Figure 3 shows the details of the respondents' districts. The data is collected from various districts of Karnataka. One response is recorded from Chennai. 37.1% response is from Bangalore urban, whereas 19.8% are from Ramanagara, and 17.4% are from Bangalore rural district. These are the first three districts with the highest number of responses received.

Fig 4: First Contact Health Care Provider

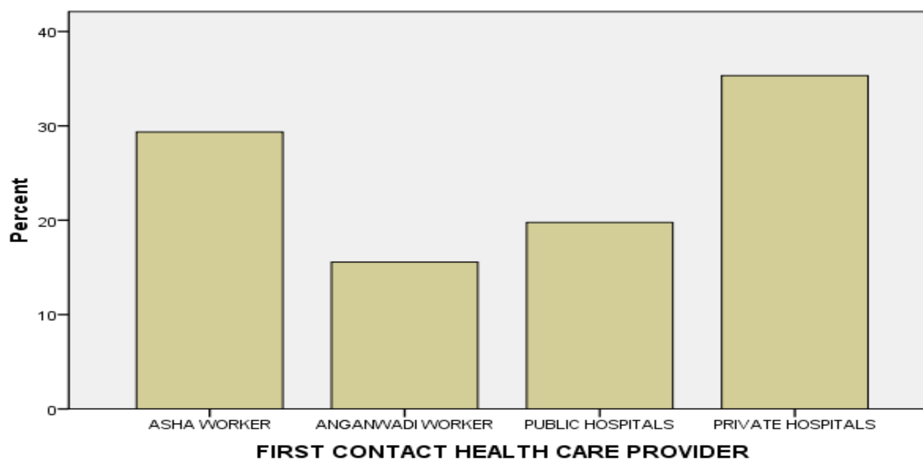

Figure 4, Bar Chart, shows respondents' views on first contact health care providers. Private hospitals stand first as the first contact health provider, according to 35.3% of the respondents. 29.3% of people consider ASHA workers as the first contact health provider, which is the second preference of the respondents.19.8% think of public hospitals, and 15.6% believe Anganwadi workers as their first contact health providers.

Table 2: First Contact Health Care Provider

First contact health care provider	Geographical Area		
	Rural	Urban	Total
ASHA Worker	37	12	49
Anganwadi Worker	16	10	26
Public Hospitals	22	11	33
Private Hospitals	17	42	59
Total	92	75	167

Source: Primary data

Table 2 is a Cross tabulation analysis of the respondents' opinions on first-contact health providers based on geographical area. It distinguishes the collected data on geographical criteria. Among 92 rural respondents, 33 people accept ASHA workers as the first contact health provider, 22 people prefer the public hospital, 17 people like to go to private hospitals, and 16 of them prefer Anganwadi workers. In urban areas, among 75 respondents, 42 respondents prefer private hospitals as their priority, 12 respondents prefer Asha workers, ten respondents say Anganwadi workers, and 11 people prefer public hospitals as their first contact health provider.

The above table shows that most of the respondents, 42 from urban areas, prefer private hospitals, coming to rural areas, 37 respondents prefer ASHA workers as the first contact health provider.

Table 3: Health Information Services by CHWs

Particulars		Frequency	Percent	Valid Percent	Cumulative Percent
Information On Nutrition	Yes	121	72.5	72.5	72.5
	No	46	27.5	27.5	100.0
Information On Sanitation and Hygiene Practice	Yes	112	67.1	67.1	67.1
	No	55	32.9	32.9	100.0
Information On Healthy Living And Working Conditions	Yes	117	70.1	70.1	70.1
	No	50	29.9	29.9	100.0
Information On Government Services	Yes	114	68.3	68.3	68.3
	No	53	31.7	31.7	100.0
Information On Benefits Of Health And Family Welfare Services	Yes	116	69.5	69.5	69.5
	No	51	30.5	30.5	100.0
Information On Oral Rehydration Therapy	Yes	81	48.5	48.5	48.5
	No	86	51.5	51.5	100.0
Awareness About The Use Of Contraception	Yes	91	54.5	54.5	54.5
	No	76	45.5	45.5	100.0

Source: Primary data

Table 3 shows that among 167 respondents, 121 respondents have been provided with nutrition information, 112 respondents have received information on sanitation and hygiene practices, and 117 respondents have received information on healthy living & working conditions. 114 respondents agree to receive information about government services, and 116 agree on receiving information about the benefits of the health and family welfare services from Asha and Anganwadi workers. 81 respondents say they have received information on oral rehydration therapy, whereas 86 respondents said

no. 91 people among 167 say they have received information on contraception methods. Oral rehydration therapy and awareness about contraception are the least given informational service by ASHA and Anganwadi workers.

Table 4: Health Counselling Services by CHWs

Particulars		Frequency	Percent	Valid Percent	Cumulative Percent
Counselling On Birth Preparedness And Institutional Delivery	Yes	107	64.1	64.1	64.1
	No	60	35.9	35.9	100.0
Counselling On Breast And Complementary Feeding	Yes	106	63.5	63.5	63.5
	No	61	36.5	36.5	100.0

Source: Primary data

Table 4 gives information about the health counselling services provided by Asha and Anganwadi workers. 64.1% of respondents have said they have received counselling on birth preparedness and institutional delivery, whereas 35.9% said they had not received the service. Counselling on breast and complementary feeding is given to 63.5% of the respondents and not given to 36.5% of the respondents.

Table 5: Health accessibility services by CHWs

Particulars		Frequency	Percent	Valid Percent	Cumulative Percent
Assistance To Get Immunisation & Vaccination	Yes	125	74.9	74.9	74.9
	No	42	25.1	25.1	100.0
Assistance To Get Post-Natal Checkups	Yes	93	55.7	55.7	55.7
	No	74	44.3	44.3	100.0
Availed Any Immunisation & Tablets	Yes	99	59.3	59.3	59.3
	No	68	40.7	40.7	100.0
Availed Any Contraceptive Measures Eg. Oral Pills, Condoms.	Yes	31	18.6	18.6	18.6
	No	99	59.3	59.3	77.8
	Na	37	22.2	22.2	100.0

Source: Primary data

CHWs assist in accessing health services by providing immunisation and tablets at doorsteps. Table 5 shows 74.9% of the respondents among 167 responses taken assistance from CHWs to get immunisation and vaccination. 55.7% of respondents have received help to get post-natal check-ups, whereas 44.3% have not availed this service from CHWs. 59.3% of the respondents have taken immunisation and tablets from CHWs, whereas 40.7% have not satisfied of this service. 18.6% of the respondents have taken oral pills and condoms as contraceptive measures, whereas these services have not helped 59.3% of the respondents. 22.2% of respondents say not applicable because they have undergone female sterilization.

Table 6: Views of Respondents on Sharing Health Conditions with CHWs

Particulars	**Frequency**	**Percent**	**Valid Percent**	**Cumulative Percent**
YES	119	71.3	71.3	71.3
NO	48	28.7	28.7	100.0
Total	167	100.0	100.0	

Source: Primary data

Table 6 shows the respondents' views on sharing health conditions with CHWs. Table 7 presents the data that 71.3 % of the respondents feel safe, and 28.7% do not feel safe sharing their health conditions with CHWs.

Table 7: Respondents' opinion on recommending the CHWs service in Health Care

Particulars	Geographical Area		Total
	Rural	Urban	
Strongly recommend	18	14	32
Recommend	13	9	22
Neutral	17	15	32
Dis recommend	23	14	37
Strongly dis recommend	21	23	44
Total	92	75	167

Source: Primary data

Table7 shows the cross-tabulation of respondents' views on recommending the CHWs health services and their geographical settlement. Among 167 respondents, 92 people are from rural 75 people are from urban areas. 32 respondents strongly recommend the CHWs health service, whereas 44 respondents strongly disrecommend the CHWs services.

Among the strongly recommended, rural respondents are high compared to urban areas, and in the strongly disrecommend group, urban people are in an increased number of 23 respondents.

DISCUSSION

The study tries to assess the significance of CHWs in the Indian public health system. Hence, the researcher has recorded the responses from women about the health services delivered by CHWs, such as information on health & hygiene, counselling services and helping in access to primary health care.

The responses have been collected from different districts of Karnataka. 92 respondents belong to rural settlements, and 75 are from urban areas. In rural areas, 37 people have two children, whereas 41 people have a single child in urban areas. CHWs have given informational services and counselling services to most of the people among the respondents. The information on nutrition and health access services for immunisation and vaccination are the highest received services from the respondents. Oral rehydration therapy, awareness about contraception, and access to contraceptive measures such as oral pills and condoms are the minor services received by respondents through CHWs among all the health services. Only 18.6% of respondents accessed oral pills, condoms and other facilities for contraceptive measures.

The study shows different opinions among urban and rural respondents about CHWs health services. In urban areas, among 75 respondents, 42 people consider private hospitals their first healthcare provider. Whereas in a rural area, 37 respondents believe only ASHA workers as their first healthcare provider among 92 people.

Though the CHWs potential is identified, their services are not highly appreciated. While giving an opinion about recommending the CHWs health service in the future, 54 respondents recommend the service. 81 respondents disrecommend the services provided by CHWs. Though they are putting all their efforts into fulfilling their responsibilities, most of the respondents opine not to recommend CHWs for health services.

CONCLUSION

- **Training and Capacity Building:** These two components are the avenues for career progression for CHWs to get higher cadres, such as Auxiliary Nursing Midwives. The training and capacity-building program must be created and delivered to them so they can step ahead in their career. It should not merely be a certificate programme. The training must also be enhanced to contribute to the promotive and preventive services.
- **Fixed remuneration:** Fixed monthly payments and incentives should be given to them as they work longer hours than their work time. The government should develop mechanisms and provide serious consideration to solving the demand of CHWs.

LIMITATIONS AND FURTHER RESEARCH

Future research should concentrate on how to develop institutional mechanisms for capacity building, training and retention of CHWs in the Indian Public health system and increase their role in health service delivery. The government and NGOs should play a vital role in training and capacity building for the CHWs to promote health in the community.

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