SciMedCentral Annals of Community Medicine and Practice

Perspective

Forty Years Post Alma Ata: Current Challenges and Future Vision for Frontline Workers in the Indian Public Health Services

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Submitted: 09 October 2018

Accepted: 23 October 2018

Published: 25 October 2018

ISSN: 2475-9465

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PERSPECTIVE

Forty years ago in the month of September, India was one of the signatories of the declaration of the Alma Ata that aimed for "Health for all by 2000 A.D." This declaration placed health care among other determinants of health. It asked countries to commit for education, sanitation, nutrition, water supply, maternal and child health and curative care for all.

The transfer of information and interventions from health professionals to the general public was envisaged as an integral part of health care. The involvement of Community Health Workers (CHWs) or village health workers as they were called, was given due importance in this context. It originated from an understanding of people-centered health, where the community itself was seen as a resource in its own health care. The Alma Ata vision also saw CHWs not as isolated programs but as a part of a structured health care work force.

Currently, the public health care services of India do extend to every village and slum today due to the presence of the largest global woman workforce of CHWs. Under the Integrated Child Development Scheme, there are 2.7 million Anganwadi Workers and Anganwadi Helpers. Under the Accredited Social Health Activist program, there are 0.87 million rural Accredited Social Health Activists (ASHA) and along with their counterparts the Urban Social Health Activists (USHA) working in slums, they would add up to another one million CHWs. There are 2.8 million Midday Meal Workers. Of these, the Asha program that has structured training modules has grown at an accelerated pace since it began in 2005.These CHW sex tend maternal and child health services, nutrition, education and a host of primary healthcare services to the poor. In the fast changing scenario that is the Indian public health care services today, new programs are constantly being added, and these village women are given new tasks regularly.

This entire vast CHW woman workforce is trained by the local full time health workers of the government in conjunction with the civil society. These frontline workers are placed within a three tier health care structure, from 5000 to20000/30000 to 100,000 population levels in the rural areas. Their urban counterparts working in slums are placed in a sparser public health setting with dispensaries [clinics], urban health posts and hospitals.

These CHWs are all supervised by the full time public health employees. We have women Asha Facilitators, male Multi-Purpose Workers, Health Assistants, and some other vertical program workers at the community level. There are around 19 million Auxiliary Nurse Midwives (ANMs) and Lady Health Visitors (LHVs) at the community level. At all the levels of the three tier facilities, in varying proportions, there is a fulltime workforce of doctors, nurses, technicians like pathologists/ pharmacists and the administrative and support staff. There are ambulance services with dedicated help lines available. Public-private partnership is seen in various models of health insurance programs.

That the country consistently maintains and runs such a vast public health workforce for decades is notable, despite the very real fact that the quality of health services is uneven across the vast geographical varied stretch that is India. The selection, training and supervision of a still expanding vast number of women CHWs each working from their own villages, is another notable achievement in itself.

Then comes the question of the impact of the CHWs upon the health care of the population that they are designated to serve. It is often said that 75% of the total healthcare services available in India, are in the vastly unregulated private sector. It is time to revisit this overused statement. While it is true that curative care is largely in the domain of the private healthcare sector, there are sections of the tribal and poor, the women and the children, that get their curative care from the public health services too. It is also a fact that the preventive and promotive health services in the villages and slums are almost completely handled by the public health care services system. This is made possible by these frontline workers backed by the graded health care services. Although a lot remains to be done, significant strides have been made in controlling infant and maternal mortality and in disease control.

Despite these very real advancements, CHW programs are delimited in their scope of operations, as they do not have a

Cite this article: *Bhatia K (2018) Forty Years Post Alma Ata: Current Challenges and Future Vision for Frontline Workers in the Indian Public Health Services. Ann Community Med Pract 4(2): 1038.*

permanent place within the public health care services system in India. The CHWs are designated as volunteers and paid task-based amounts that are termed as incentives. These programs are the joint jurisdiction of the Central and state governments. In 2018, the Centre has announced a new raise, however the total Central government base incentive for the Asha today is around 30$ /month and of Anganwadi workers around 50$/ month. In addition, Asha workers get varying amounts as task-based incentives. Some States also add a proportionate allocation of incentives. Being a federal government, the State share in the incentives varies, as each State can decide to whether to augment or forego their own contribution to the basic Central government incentives.

A recent official announcement was made for the life insurance coverage and accident coverage for CHWs. Some States do recognize the efforts of these workers by way of "Best worker" announcements and felicitations. Apart from these, there are no other benefits as there is no health care coverage, retirement benefit or stable career advancement ladder.

Three interrelated and underlying factors are accountable for this situation. These are the triumvirate of Hierarchy-Gender-Informalisation of public health services. Health care services are normally hierarchical and patriarchal structures, and to add to this is the fact that the first Indian public health services were by the British military, for their soldiers that were posted in India during British rule.

While running such a massive infrastructure today would require well defined systems and processes, we also seem to have inculcated the culture of hierarchy and deference to authority on pain of punishment. It is not surprising that the foot soldiers bear the brunt of the inherent authoritarianism. And so we see unofficial "task-shifting" at local levels of health care, and a general lack of regard for the work of CHWs, who are in no position to complain, being volunteers. The community too is generally the recipient of their services and not champion for their well-being. The trade union movement and CHW associations focus largely on getting CHWs better payments. Incentives have risen over the years, but in an erratic fashion, as incentives to volunteers need not adhere to any labor laws or the minimum wages norms. The Anganwadi CHWs have been volunteers since 1975. The Asha workers are volunteers since 2005.

The voluntary status of CHWs is best seen within the larger context of the structure of the public health care services system. While India has a stable and permanent public health care workforce, there has been a large scale expansion of the work force under the National Health Mission (NHM) since the past two decades. An additional workforce of contracted workers now operates along side the permanent cadres, in upgraded health facilities. All the workforce of NHM from doctors and nurses to technicians and administrative positions are under renewable contracts. Living with lesser wages and no job security, these workers are a part of the informalisation process, along with the CHWs. Their associations demand for regularization of their services, while the government faces human power shortages in several areas.

Adding to the complexity of the public health care system, is the recently announced health insurance program Ayushman Bharat, where the government subsidizes hospitalization for urban and rural poor that meet a pre-decided income criteria in empaneled hospitals. Alternatively hailed as progressive or as encouraging privatization, it leaves CHWs in a confused situation. On the one hand, all the primary health functions like nutrition, maternal and child health, prevention of communication diseases and family planning are with the government and these are directly within the domain of CHWs. CHW are being given an increasing number of tasks under increasing programs, including cash benefits for safe delivery . On the other hand, while there are commitments to increase the spending, these are yet to materialize. The civil society is largely pre-occupied in safeguarding the health care rights of the community, with sections being skeptical about the relevance of such large CHW forces, in the face of the overwhelming presence of privatization and the informalisation of the public health care services.

CHWs are roped in to identify potential beneficiaries for public and insurance programs, while not being entitled to any such benefit themselves. The gender bias in this situation can be seen in the fact that these CHWs are all women. Living and working in a patriarchal society and working environment, with the inherent safety concerns, they are rendered more vulnerable due to the lack of fair working wages and complete social security. Although the chances for permanent positions seem improbable today, this is the vision of their associations.

The Alma Ata vision of frontline workers was one where they would be a part of a stable and structured health care work force. Health care itself was part of a broader vision of the social determinants of health. Reforms and investments in the human resources for health aiming towards stability, regulation of the private sector, and far more investments in nutrition, water supply and education are required. India has a unique and large scale sanitation program that must be up scaled qualitatively. Reforms and expansions in medical and nursing education are needed, but there need to also be planned avenues for more women, for social scientists, psychologists and communication experts in health care. Front line workers will get their due place only when health is seen as quality of life and not as delivery of services [1-3].

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Bhatia K (2018) Forty Years Post Alma Ata: Current Challenges and Future Vision for Frontline Workers in the Indian Public Health Services. Ann Community Med Pract 4(2): 1038.