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Caught in a Bind: The Ubiquitous CHV

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Under the health program covered by the primary health centers (PHCs). The major link between the PHCs and the village of communities is provided by the community health volunteers (CHVs). Formerly, these were mostly men; but as men did not prove to be quite so "effective', the roles have been transferred to women, although in an occasional village male CHVs still continue to function. The issue of effectivity is camouflaged in statements, like, "women work more sincerely than men"; "cultural barriers prevent males from reaching out to the female population", etc. While these reasons may not be entirely baseless, the very obvious correlation between intensified promotion of family planning and the switchover from male CHVs is too obvious to go unnoticed.

Selecting Health Workers

The normal procedure for the selection of CHVs is through nomination by the gram panchayat (elective village body for self-administration). In practice this is not strictly followed. Often the PHC nurse during her village rounds establishes contacts with the women and, in the process, informally discusses the work of the CHV with potential candidates. In such discussions, no details are given -just that the CHV will be given training, will then be given a kit to disburse medicine to any villager who comes and asks her for them and will have to accompany the nurse on occasional rounds in the village. "How often these rounds are to be is not specified. For this, she is told that she will be paid a monthly salary (although this is an honorarium it is referred to as "paggar" - salary) of Rs 50. Once she has agreed, the 'formal channels are put into gear. The sarpanch. gram sevak and talatti are approached by the nurse and once- they certify the candidate's credentials, she is put through an orientation program made to fill in a form (for which she pays Rs 7) in which she also signs a bond for a three-year failing which she would have to pay Rs 600 to the concerned PHC.

The initial orientation extends over a three-month period. Earlier the training sessions used to be held five days a week, now these have been cut down to three days a week. During this training period the CHVs are given a general orientation about the symptoms and medicine dosages for common illnesses, first-aid in case of accidents or bites, how to take blood and sputum samples, etc.

The social aspects of various ailments are completely overlooked. The fact that the CHVs are 'voluntary social workers' and are appointed to serve the people who cannot afford to go to doctors is stressed. The focus is on program implementation, not so much on understanding the objectives of the community health program. On successful completion of the orientation program and after signing the bond each CHV is given a kit containing analgesics like paracetamol, analgin tablets for gastric troubles and acidity, syrups (kaolin and pection solutions) for diarrhoea and rehydration powder, cough mixtures, various medicines to treat skin allergies, wounds, sprains muscular pains, conjunctivitis and eye irritation, oral pills and condoms, bandage gauze and gauze (without cotton for use during menstruation) etc. For pregnant women a stock of 90 Iron tablets are kept irrespective of the actual needs.

After this Initial orientation program there are periodic (though not regular) refresher camps. Basically as a revision of whatever has been taught earlier. Besides this, there are the monthly meetings at the PHC subcentre during, which they have to carry a certificate of satisfaction from either, the gram sevaks or the sarpanch and submit their records. Refill their, kits and pick up their honorarium. Occasionally there are lectures by doctors focusing on target fulfillments.

Hidden Goals

The CHVs get a real picture of the volume of work extracted out of them only when they actually begin to function. While they are told that they are expected to put in two hours of work everyday in actuality the average amount of work amounts to, much more. Their task includes giving away medicines, regular home visits to motivate couples for family planning, accompanying the PHC subcentre nurses on their regular (weekly or fortnightly) rounds, preparing monthly records of births deaths and, another one to the PHC sub-center. Besides this periodically they are also given the task of distributing milk to children (pre-schoolers) who fall under the category below poverty line. Although there are supposed to be separate malaria 'doctors' (community level workers. mainly youth. who are part of the malaria eradication network and are appointed seasonally) the work of collecting blood samples from. Patients having fever is also given to the CHVS. Each month the CHVs are expected to give at least one dozen packets of "Nirodh" to every married male, bring in at least one case for sterilization or three cases for IUD (copper T) insertion and collect an average of 15 blood samples. The work of motivating people to participate in family planning or other camps whenever the, occasion arises separately.

As is obvious from the above the focus of work of the CHV is almost entirely to curative aspects and being part of the team, which has an obligation to fulfill targets as demanded by the existing policies.

While the public health program comes directly under the district health officer in the zilla parishad, the CHVs are neither aware of, nor do they have any contact with higher administrative authorities even at the taluka level. The major channels of communication are with the PHC or sub-center nurse for their area and the area public health doctor. These are the functionaries who issue 'orders' and perform supervisory roles. The CHVs are also accountable to the gram panchayat. Occasionally they may be answerable to the doctor-in-charge of the taluka level PHC, but this is more the exception than the rule as the taluka PHC doctor is not regularly in contact with the CHVs coming under the auxiliary units. His "dialogue" is generally confined to discussions with sub-center staff and the occasional lectures to the CHVs during monthly meetings.

The CHVs are amongst the lowest rungs of the rural public health program and are, as such, expected to implement whatever programs are handed to them. In the absence of any channels to voice their difficulties or air grievances, this, in effect, amounts to simply carrying out orders. The extent to which these are actually carried out depends a good deal on the individual sincerity of the CHVS, the kind of relationship they have with the supervisory nurses and, the image that gets projected to the doctors.

At the community level, there appears to be in general a definite enhancement of status as they begin to interact with different households, irrespective of caste or community and gradually begin to be looked upon as persons who can give advice (particularly to women) about their health problems. 0f course, to a large extent, the personality and enterprise of the individual CHV is also important as far as the relationship with the community goes. The major obstacle to their acceptance in the community is caused due to the pressure to fulfill family planning targets. They feel that today women have become much more aware of the need to practice birth control because of the increasing financial strains. In fact this seems be the major motivational factor rather than the aspect of their effects on women's health. They admit that women are more easily motivated to practice family planning rather than men firstly because they feel that they have at stake and secondly, because of the Popular myths about the negative effects of family planning devices on males. It is not uncommon to find CHVs themselves believing in such myths.

The negative effects of birth control measures are not matters of deep concern partly because the CHVs do not have sufficient data to fall back on. If they

sometimes carry post sterilization or IUD complaints to doctors, they are often told that there is no connection between the two. Another reason for this lack of concern is the deeply ingrained notion that women are born to bear pain and should not therefore fuss overmuch about such things.

No Way Out?

(i) The issue of 'voluntary social service' in relation to CHVs runs contradictory to the expected output and nature of interaction between the CHVs and their supervisory staff. It is true that the honorarium is looked upon as a salary and given the workload, the CHVs definitely feel that this salary is far too inadequate. At the same time, in the absence of any organized efforts the CHVs prefer to voice their resentment privately, no matter how small the amount paid, the extra income is still welcome.

(ii) The pressures from above to exhaust their stock (irrespective of the utility of certain medicines) and to fulfill targets, encourages cheating (making bogus records, etc.), affects their motivation and interest. Where FP targets are concerned the CHVs have to strain their energies through a great deal of tact.

(iii) There are no regular channels to air even genuine grievances. In fact CHVs who bring up complaints regularly are scolded and accused of not working hard enough or not showing enough initiative. At other times it is a game of passing the buck. As a result there is a tendency to become mechanical with a great degree of indifference to crucial issues chat are faced by women.

(iv) It has come to our notice that there are certain unofficial CHVs. These are women, who due to various reasons have not undergone any orientation and therefore, neither receive an honorarium, nor do they have any direct contact with the PHCs. They work on an informal understanding with guidance from the PHC nurse who signs all records. These women are not aware of the procedural conditions or any other matter beyond what the nurse tells them. While such cases, may be rare they do deserve further investigation.

(v) While the CHVs are equipped with a fair variety of medicines, the extent of utility of some of these remains a point in question. Many CHVs are not aware of the likely negative effects of certain drugs (including oral pills); certain medicines or materials, which would be useful are not included in the kit and sometimes filling up the stocks of certain medicines is a problem as the area PHC units claim that they do not get their supply regularly.

(vi) At the moment the work of the CHVs is along conventional lines and target-oriented. In order to make the program more people-oriented (and specifically

women-oriented) it is necessary to build an organization wherein the health workers are given access to relevant data, as well as one, which would help raise problems and questions. This would mean an organization, which focuses on the socio-political aspects of health and would be able to initiate action to bring necessary changes in the health system. However, at present at least there appears to be practically no response to building such an organization at the local level, on the part of the CHVs. It appears that, partly, these women are afraid to voice their protest for fear of losing their jobs, which would mean loss of money as well as social status. The other aspect is linked with the kind of community and familial pressures women face in participating in any kind of political organizing within a patriarchal society.

The public health program implemented through the CHVs is a program, with tremendous potential to revolutionize the rural health system but not in the way that it functions at present. While, without doubt, the social mobility of women CHVs has visibly helped to enhance their status and sense of self confidence, in order to make the program deeply relevant to women it is necessary to develop a wider social and feminist perspective on health at. Different levels, most crucially at the level of the, CHVs. At present the public, health program offers a package, which is technical and target-oriented (with women as its special target) and in fact serves to perpetuate patriarchal values most particularly obvious in its obsession with family planning. Bringing about a change in the perspective of women health workers could form a crucial opening to revolutionize the ideology of the grassroots level health system. It goes without saying that such changes could never be brought about unless they are supported by, and are a part of, a wider people's struggle, which basically questions, attacks and seeks to change the existing class, caste gender, race and human nature equation.