COMMENTARY

From the frontlines to centre stage: resilience of frontline health workers in the context of COVID-19

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Introduction

Community health workers (CHWs), a largely invisible and undervalued resource within India's health system, have come into the spotlight of policy and public discourse since the COVID-19 pandemic. Although the role of India's more than two million (all women) Accredited Social Health Activists (ASHAs), Anganwadi Workers (AWWs), and Auxiliary Nurse Midwives (ANMs) in educating and mobilising communities to demand and utilise public health services is well-known, CHWs have received little attention, investment in their capacities, opportunities for voice and influence, and remuneration.[1] However, India's response to the COVID-19 pandemic has relied heavily upon them for community outreach, delivery of relief, surveillance, and adapting and maintaining essential service delivery, and their increased prominence has led to new health system efforts to support and empower them. In this commentary, we reflect on the opportunities and implications for leveraging this momentum to build a more resilient, gender equitable and community-engaged public health system.

Legacy issues: struggles of a low-performance system

The prominence of CHWs during COVID-19 comes at a time when their critical role in achieving universal health care is being increasingly acknowledged,[2,3] particularly in health system outreach to women for sexual and reproductive health services (SRHS), and other primary health care services such as maternal, newborn and child health (MNCH), and increasingly for identifying and supporting people living with chronic diseases. Evidence shows that door-to-door counselling and community outreach to women does lead to improved health and nutrition behaviours and service uptake such as routine immunisation, contraceptive use, and infant feeding practices.[4]

In India, however, the coverage and quality of services provided by CHWs remains variable. For example, in Bihar, only 37% of pregnant women and 54% of children under the age of three receive any benefit from Anganwadi Centres (sites of delivery for maternal and child health and nutrition services).[5] Our ongoing research has explored the cause of this low performance using the framework of Means, Motives, and Opportunity.[6] Overwhelmingly, we find that opportunity factors outside the control of CHWs, grounded in the structure and functioning of the system, are the most binding constraints to improving the coverage and quality of services. CHWs lack basic infrastructure and supplies and are responsible for large catchment areas, which undermines accessibility and their personal safety.[7] More fundamentally, CHWs need to be trusted and respected to influence and mobilise community members whilst navigating the complexity inherent in communities.[8,9] Women have been recruited as CHWs precisely because of their ability to access and reach other

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women with health education and preventive services. However, consonant with health systems in other parts of the world, gender biases, lack of power, and discrimination shape the ways in which CHWs in India are treated.[10–12] CHWs are often publicly admonished by punitive supervisors, compensated via incentives and honoraria (as opposed to fair wages), and receive woefully delayed payments.[6,13,14] Despite these issues, we find no evidence that low performance stems from the fact that CHWs shirk their duties. For example, in Bihar, we found that 90% of CHWs undertook the processes required to facilitate service delivery, including creating a home visit plan, surveying pregnant women and children and supporting the preparation of due lists.[15] In general, CHWs are poor women with limited alternative livelihood options and their desire to keep their job (along with other moral and social motivators for undertaking the work) ensures continued effort and process compliance.[16]

These issues have been well-documented over decades of research on India's CHWs, yet policy reform to create the enabling environment for CHWs has been painfully slow, again reflecting the lack of power and voice of a feminised workforce.[17]

Contemporary issues: moving to the centre stage

In this time of COVID-19, the national and state governments of India have rightly recognised the critical role to be played by community-based health workers. CHWs have been galvanised to play a range of roles: raising awareness and disseminating information on preventive measures; engaging in community surveillance, including contact tracing; conducting door-to-door surveys to assess returning migrants; delivering take-home rations; and addressing myths and misconceptions to mitigate stigma and discrimination. A month into the COVID-19-related lockdown, attention also turned to the continuation and resumption of essential health services, particularly those related to sexual and reproductive health.[18,19] CHWs have played a vital role here as well, adapting outreach efforts and managing the complex trade-offs between ensuring vulnerable groups such as pregnant women and newborns can access healthcare services, whilst minimising the risk of further propagating COVID-19 and adapting for changed community needs arising from the pandemic (including increased contraceptive needs and abortion related services and care). Essentially, they have become a trusted workforce liaising between state health systems and communities.

In this short time, the health system has rapidly improved its support of CHWs through digitally enabled training, increased remuneration, and occupational support. By early April, the Government of India had assembled and begun to disseminate a large amount of content (including guidelines, PowerPoint decks, and videos) for training CHWs in the roles detailed above using digital technology such as video conferencing and the newly launched Integrated Government Online Training platform. Supervisors and managers have used phones (audio alone/with video) to track and supervise activities.[20–23] The Government of India announced special incentives and health insurance coverage for all CHWs involved in the COVID-19 response, and some states have provided additional incentives.[24–26] The Bihar government has striven to recognise and sustain the motivation of CHWs by publicly felicitating them as "stars", as well as through phone calls by senior health officials to express appreciation.[27]

Leveraging momentum: addressing novel and existing challenges

While such recognition is laudable, the mandate outlining the responsibilities of CHWs and the expectations of their significant role in the COVID-19 response also reveal little or no shift in legacy issues of high workload, persistent constraints, poor support, and limited agency in decision making relating to their work. The limited power and positionality – amplified by gender considerations – of CHWs within the system continues to constrain how the system responds to their needs. In our ongoing research and as reported widely in the media,[28] CHWs have been engaged in screening and quarantining very large numbers of people without always having adequate personal protective equipment, leaving them highly vulnerable to contagion.[29,30] In addition to COVID-19 outreach work, the need to continue providing essential services has substantially increased CHWs' workloads.[31,32] The disruption of their routine work has meant less incentive-based income and may therefore, on balance, lead to income uncertainty.[33] CHWs are still the lowest tier in a hierarchical system and have had

to make quick changes to their daily routines, without the system understanding the implications for their safety and personal lives. Despite the magnitude of the workload and attendant risks, there has been limited attention to the psychosocial well-being of CHWs.[34] At the community level, harassment and disrespect fuelled by fears of COVID-19 have been reported. That said, these incidents have also been the impetus for the passage of an amendment to the Epidemic Diseases Act 1897 that provides special protections from acts of violence against healthcare workers and the launch of anti-stigma campaigns.[35] Remuneration troubles persist, however. CHWs report lags in receiving official incentives, with many not having received their dues for several months.[36]

Overall, the engagement of CHWs in the COVID-19 response is key to the government's efforts to contain the spread of the disease. Yet the support they have received continues to be incommensurate to their pivotal role.

As Charles Dickens once wrote, it is the best of times and it is the worst of times. Because CHWs have received unprecedented attention and appreciation, this is an opportune moment to push for substantive and sustained changes to respond to their needs and enable them to occupy a more empowered position within the health system.[1,37] We need focused effort drawing on available evidence and insights to sustain and build on the progress we have seen in the last few months. Notably, lauding CHWs for their efforts is a step in the right direction. However, along with greater recognition, a rationalisation of their workload is in order. The COVID-19 benefit package is a positive step but is time-bound; streamlining CHWs' remuneration to ensure fair compensation and greater economic security[1] can help boost their status within the health system, community and families. Adoption of supportive supervision can help CHWs overcome performance challenges (including those caused by system constraints) and empower them to perform.[38] Training that is fit for purpose, prompt, and covers transferable skills such as communication is essential to improve both performance and motivation.[38,39] Lastly, CHWs should include male and female health workers accorded with equal professional skills and status. Feminising the workforce of community health workers and keeping them underpaid or unappreciated does not bode well for gender equality or enabling universal health coverage. The pandemic has taught us that it is time to plan for a forward-looking resilient health system that values its health workforce to address the diverse and pluralistic needs for primary health and recognises the critical need for empowered, trusted and performant CHWs in achieving universal health coverage.[40]

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